

Case Number:	CM14-0032157		
Date Assigned:	06/20/2014	Date of Injury:	11/24/2011
Decision Date:	07/17/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	03/13/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 57 year-old patient sustained an injury on 11/24/11. Diagnoses include metatarsus nonunion fracture; mechanical orthopedic device complication implant and graft. Report of 10/9/13 from the provider noted bilateral foot pain; increased right knee pain with orthotics, needing modification. Therapy reduces pain and increase functional capacity. No exam was recorded. Treatment plan included modifying orthotics; home exercise; continue PT 2x6; knee sleeve and balance trainer. Report of 12/4/13 from the provider noted patient unable to wear regular shoes because of lack of support. She is allergic to most medications. No physical examination was documented/performed. Treatment included orthotics, neurostimulator unit and heating system. Report of 1/15/14 from the provider noted ongoing right foot pain. Treatment included orthotics, work conditioning, home exercise, acupuncture, and EMG unit and Solo care.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

X-FORCE STIMULATOR UNIT PURCHASE PLUS 3 MONTH SUPPLIES, AND CONDUCTIVE GARMENT X 2 FOR THE RIGHT FOOT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, interferential stimulation is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of transcutaneous stim unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication and therapy not demonstrated here. It appears the patient has received extensive conservative treatment to include medications and exercise which is documented to control of symptoms. There is no documentation on the short-term or long-term goals of treatment with the neurostimulator unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the unit as there is no documented failed trial of basic TENS. There is no evidence for change in work status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from any transcutaneous stimulation therapy already rendered. The request is not medically necessary and appropriate.

SOLAR CARE HEATING SYSTEM PURCHASE FOR THE RIGHT FOOT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cold & Heat Packs.

Decision rationale: Regarding Hot/Cold therapy, guidelines state it is recommended as an option after surgery, but not for nonsurgical treatment. The request for authorization does not provide supporting documentation for purchase beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines which note local application of heat or cold is as effective as those performed by therapists and high tech devices have not demonstrated superior efficacy over the use of traditional non-motorized heating pad modalities. MTUS Guidelines is silent on specific use of hot/cold compression therapy, but does recommend standard hot/cold pack with exercise. The request is not medically necessary and appropriate.