

Case Number:	CM14-0047155		
Date Assigned:	07/02/2014	Date of Injury:	12/02/2010
Decision Date:	08/21/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	04/15/2014

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 Family Medicine and is licensed to practice in Arizona. 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:

Patient is a 47 year old female with a date of injury on 12/2/2010. Diagnoses include cervicalgia, brachial neuritis, and shoulder/arm sprain. Subjective complaints are of cervical and thoracic pain. Physical exam shows tenderness over cervical paraspinal muscles and decreased range of motion. Medications include Motrin, Insulin, Lisinopril, and medicated lotions. Prior studies include x-rays of the right shoulder, hand/wrist, elbow, and electrodiagnostic studies that revealed carpal tunnel syndrome. Cervical spine CT scan showed damage over C4-5. Patient had been certified for 8 visits to physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective review for Prime IF Unit and Supplies (DOS 3/13/2013): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS
Page(s): 114-115.

Decision rationale: CA MTUS does not recommend interferential current stimulation as an isolated intervention. But CA MTUS does suggest it is possibly appropriate to have a one month trial if the following criteria are met: Pain is ineffectively controlled due to diminished

effectiveness of medications; pain is ineffectively controlled with medications due to side effects, or there is significant pain from postoperative or acute conditions that limits the ability to perform exercise programs/physical therapy treatment; or unresponsive to conservative measures. For this patient, there is no objective evidence submitted of a one-month trial. Furthermore, the records do not indicate that the patient was unresponsive to medication, and records did not identify other conservative measures that had been utilized. Therefore, the medical necessity of an interferential unit is not established at this time.

Retrospective Motorized Cold Therapy Unit (DOS 3/13/2013): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC, Neck and upper back chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Cold Packs, Shoulder, Cryotherapy.

Decision rationale: CA MTUS suggests local application of cold packs during the first few days of acute complaints. The ODG recommends continuous cryotherapy as an option after surgery, but not for nonsurgical treatment. For this patient, records do not identify an acute injury or recent surgery for which cryotherapy would be indicated. Therefore, the request for a cold therapy unit is not consistent with guideline recommendations, and the medical necessity is not established.

Retrospective Moist Heating Pad (DOS 3/13/2013): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Heat/Cold Applications.

Decision rationale: The ODG states that insufficient testing exists to determine the effectiveness of heat/cold applications in treating mechanical neck disorders, and local applications of cold packs may be applied during the first few days of symptoms followed by applications of heat packs to suit patient. The submitted records do not indicate any acute injury or acute exacerbation of a chronic problem. Furthermore, records do not indicate rationale for the purchase of a specific type of heat pack, and the anatomical area for it to be applied is not identified. Therefore, the medical necessity of a hot pack is not established.