

Case Number:	CM14-0081037		
Date Assigned:	07/18/2014	Date of Injury:	11/12/2013
Decision Date:	08/25/2014	UR Denial Date:	05/22/2014
Priority:	Standard	Application Received:	06/02/2014

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 Texas and Ohio. 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:

The injured worker is a 53-year-old male with a reported date of injury on 11/12/2013. The injury reportedly occurred when a metal partition fell on the injured worker's head, neck and left shoulder. His diagnosed were noted to include cervicalgia, left shoulder impingement syndrome, cephalgia and dizziness. His previous treatments were noted to include ice and over-the-counter pain relievers. The progress note dated 04/17/2014 revealed that the injured worker complained of headaches rated at a 4/10. The injured worker also complained of constant stabbing pain in the neck, rated at a 5/10, and aching pain in the left shoulder, rated at a 6/10. The physical examination revealed that the injured worker had a positive O'Donoghue's sign with cervical flexion and extension. The provider revealed that the injured worker had a negative Spurling's test, and the cervical compression and distraction tests were positive. The range of motion to the cervical spine was revealed to be flexion of 30 degrees, extension of 40 degrees, right/left rotation of 60 degrees and right/left lateral flexion to 40 degrees. The physical examination of the left shoulder revealed a positive impingement sign, a positive supraspinatus press test and a positive Apley's scratch test. The range of motion of the shoulders was revealed to be flexion of 160 degrees, extension of 30 degrees, abduction of 160 degrees, adduction of 30 degrees and internal/external rotation of 60 degrees. The Request for Authorization form dated 04/17/2014 was for a multi stim unit plus supplies as a 5 month rental, a heat/cold unit as a purchase and a cervical home exercise rehabilitation kit; however, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi Stim unit times 5 months rental plus supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain Page(s): 114-116.

Decision rationale: The injured worker has been utilizing ice and over-the-counter medications for pain. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines do not recommend a TENS unit as a primary treatment modality, but a 1 month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. The guideline criteria for the use of a TENS unit are evidence that other appropriate pain modalities have been tried (including medications) and failed; a 1 month trial of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial period. Other ongoing pain treatments should also be documented during the trial, including medication usage. There is a lack of documentation regarding the failure of conservative treatment to warrant a multi stim unit. Additionally, the guidelines recommend a 30 day trial, and the request for a 5 month rental exceeds the guideline recommendations. Therefore, the request is not medically necessary and appropriate.

H/C Unit Purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse, Medline, Cinahl, and The Cochrane Library.

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

Decision rationale: The injured worker has been utilizing ice and over-the-counter medications for pain. The Official Disability Guidelines recommend cold packs. Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders though, due to the relative ease and lack of adverse effects, local applications of cold may be applied during the first few days of symptoms followed by applications of heat packs to suit the injured worker. The guidelines recommend cold packs for the first few days of treatment and then applications of heat to suit the injured worker. The guidelines recommend cold packs the first few days of injury and then heat packs to suit the injured worker which does not necessitate a heat/cold application purchase. Therefore, the request is not medically necessary and appropriate.

C/S Home Exercise Rehab Kit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46.

Decision rationale: The injured worker has been utilizing ice and over-the-counter pain medications for neck pain. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that there is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. There is a lack of documentation regarding a home exercise program has been taught by a physical therapist. Additionally, the request failed to provide the components within the request. Therefore, the request is not medically necessary and appropriate.