

Case Number:	CM14-0082215		
Date Assigned:	07/21/2014	Date of Injury:	06/02/2009
Decision Date:	10/20/2014	UR Denial Date:	05/08/2014
Priority:	Standard	Application Received:	06/03/2014

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 Occupational Medicine 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:

According to the records made available for review, this is a 60-year-old female with a 6/2/09 date of injury, and status post left knee arthroscopy, lateral meniscectomy, and debridement 12/14/13. At the time (5/8/14) of request for authorization for [REDACTED] IF 200 interferential unit and supplies, cold therapy unit, and exercise kit, there is documentation of subjective (constant pain in the upper back, pain rated 6-7/10) and objective (moderate paraspinal tenderness and decreased thoracic spine range of motion) findings, current diagnoses (displacement of thoracic intervertebral disc site unspecified without myelopathy, degeneration of thoracic or thoracolumbar intervertebral disc, thoracic spine spinal stenosis, and myalgia), and treatment to date (epidural steroid injection, lumbar brace, knee brace, and activity modification). Regarding the requested cold therapy unit, there is no documentation of a recent or pending surgery. Regarding the requested exercise kit, there is no documentation that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit.

IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] IF 200 interferential unit and supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Interferential Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 113-120.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation (ICS) is not recommended. Therefore, based on guidelines and a review of the evidence, the request for [REDACTED] IF 200 interferential unit and supplies is not medically necessary.

Cold Therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Continuous-flow cryotherapy

Decision rationale: MTUS does not address the issue. ODG states that continuous-flow cryotherapy is recommended postoperatively for up to 7 days, including home use. Within the medical information available for review, there is documentation of diagnoses of displacement of thoracic intervertebral disc site unspecified without myelopathy, degeneration of thoracic or thoracolumbar intervertebral disc, thoracic spine spinal stenosis, and myalgia. However, given documentation of a knee surgery done 12/14/13, there is no documentation of a recent or pending surgery. Therefore, based on guidelines and a review of the evidence, the request for cold therapy unit is not medically necessary.

Exercise kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

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

Decision rationale: MTUS does not specifically address the issue. ODG identifies documentation that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit as criteria necessary to support the medical necessity of a home exercise kit. Within the medical information available for review, there is documentation of diagnoses of displacement of thoracic intervertebral disc site unspecified without myelopathy, degeneration of thoracic or thoracolumbar intervertebral disc, thoracic spine spinal stenosis, and myalgia. However, there is no documentation that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit. Therefore, based on guidelines and a review of the evidence, the request for exercise kit is not medically necessary.