

Case Number:	CM14-0083261		
Date Assigned:	07/21/2014	Date of Injury:	10/15/2013
Decision Date:	09/19/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/04/2014

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 and Rehabilitation, has a subspecialty in Pain Management, 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 is a patient with a date of injury of 10/15/13. A utilization review determination dated 5/29/14 recommends non-certification of a cold therapy unit, IF unit, and supplies. 5/7/14 medical report is somewhat illegible, but appears to identify pain in the cervical, thoracic, and lumbar spine, chest, and ankle. On exam, there is tenderness noted. Recommendations include various referrals, imaging studies, and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181, 300. Decision based on Non-MTUS Citation Official Disability Guidelines, TWC Neck and Upper Back Procedure Summary Official Disability Guidelines, TWC Low Back Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Low Back, and Ankle and Foot Chapters.

Decision rationale: Regarding the request for cold therapy unit, the California MTUS does not specifically address the issue. The Official Disability Guidelines support the use of cold therapy

units for up to 7 days after surgery for some body parts, but not for nonsurgical treatment. Within the documentation available for review, there is no indication of a recent or pending surgery of a supported body part. In the absence of such documentation, the currently requested cold therapy unit is not medically necessary.

Interferential Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: Regarding the request for interferential unit, the California MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.

2 month supplies (electrodes, batteries and lead wires) for interferential unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.