

Case Number:	CM14-0004651		
Date Assigned:	01/22/2014	Date of Injury:	02/26/2012
Decision Date:	05/01/2015	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	01/10/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 56-year-old male who reported an injury on 02/28/2012. The injured worker was reportedly injured while attempting to restrain an inmate. The current request is for several durable medical equipment purchases on 05/03/2013. However, the only clinical note submitted for review is documented on 03/01/2013. The injured worker presented for a follow-up evaluation with complaints of 7/10 pain. Upon examination, there was a well-healed scar in the right upper extremity, an inability to make a complete fist, positive Tinel's sign, and tenderness at the medial elbow. The injured worker was diagnosed with right fourth and fifth tendon injury, right hand crush injury, severe right cubital tunnel syndrome, and left middle finger mass. Recommendations at that time included authorization for a right cubital tunnel release. The provider also requested a course of occupational therapy and continuation of the home exercise program. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Stimulator Purchase (DOS: 5/3/13): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 117-21.

Decision rationale: California MTUS Guidelines state interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence on the effectiveness, except in conjunction with recommended treatments. According to the documentation provided, there was no evidence of a failure to respond to conservative treatment. The guidelines further state, if the device is to be used, a 1-month trial should be initiated and documented. In this case, there is no evidence of a successful 1-month trial with the interferential unit prior to the request of right arm purchase. Given the above, the request is not medically appropriate.

18 Pack of Electrodes (DOS: 5/3/13): Upheld

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

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.

4 Sterile Electrodes (DOS: 5/3/13): Upheld

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

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.

Arm Sling (DOS: 5/3/13): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hand & Wrist.

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

Decision rationale: The Official Disability Guidelines do not recommend immobilization as a primary treatment. Early mobilization benefits include earlier return to work, decreased pain, swelling, and stiffness. In this case, the medical necessity for the requested arm sling has not been established, as there was no mention of a recent surgical procedure supporting the necessity

for an arm sling. The Official Disability Guidelines do not recommend immobilization. Given the above, the request is not medically appropriate.

Cold Therapy Unit Purchase (DOS: 5/3/13): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Continuous-Flow Cryotherapy.

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

Decision rationale: The Official Disability Guidelines state continuous flow cryotherapy is recommended for up to 7 days following surgery, but not for nonsurgical treatment. In this case, there was no indication that this injured worker underwent a surgical procedure. Additionally, the request for a unit purchase would exceed guideline recommendations of a 7-day rental. Given the above, the request is not medically appropriate.