MAXIMUS Federal Services

Case Number:	CM14-0200217		
Date Assigned:	12/10/2014	Date of Injury:	10/22/2014
Decision Date:	01/31/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/01/2014

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 Rehab, has a subspecialty in Pain 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:

The injured worker is a 34 year old male with a date of injury of October 22, 2014. Results of the injury include back pain and right lower extremity pain. Diagnosis include lumbosacral musculoligamentous strain/sprain, rule out lumbosacral spine discogenic disease, right shoulder strain/sprain, right shoulder tendinitis, right shoulder impingement syndrome, right elbow strain/sprain, right elbow lateral epicondylitis, right wrist strain/sprain, rule out right wrist carpal tunnel syndrome. Current treatment noted was cyclobenzaprine, tramadol, lumbosacral brace, inferential unit, and a hot and cold unit. Progress report dated November 7, 2014 showed tenderness to palpation and spasm to bilateral upper/mid/lower thoracic region, lumbar spine showed tenderness to palpation bilateral paraspinal muscles with back spasms. There was decreased range of motion with a positive straight leg raising test on the right. There was right shoulder tenderness to palpation with decreased range of motion. There was decreased motor strength of the right upper extremity. Work status was noted as total temporary disability. Utilization review form dated November 17, 2014 non certified an IF Unit and a Hot/Cold Unit due to noncompliance with MTUS guidelines recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit: 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 Page(s): 118-120.

Decision rationale: Regarding the request for interferential unit, the CA 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 outlined above. 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.

Hot/Cold Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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, Elbow, and Forearm, Wrist, and Hand Chapters, Continuous-flow cryotherapy.

Decision rationale: Regarding the request for hot/cold unit, the CA MTUS does not specifically address the issue. The ODG supports the use of continuous-flow cryotherapy units for up to 7 days after surgery for some body parts, but non-surgical use is not supported. Within the documentation available for review, there is no documentation of a recent/pending surgery. Additionally, an open-ended duration of treatment is not supported and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested hot/cold unit is not medically necessary.