

Case Number:	CM14-0213321		
Date Assigned:	12/30/2014	Date of Injury:	11/03/2011
Decision Date:	05/01/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/19/2014

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
 Certification(s)/Specialty: Orthopedic Surgery

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 59-year-old female who reported an injury on 11/03/2011. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of pain in limb. Past medical treatment consists of surgery, physical therapy, and medication therapy. An EMG obtained on the injured worker's right extremity revealed ulnar sensory neuropathy across the right wrist. On 10/09/2014, the injured worker complained of right hand pain. The physical examination revealed there was no clubbing, cyanosis, or edema. There was tenderness in the right hand. Strength was 5/5 in the bilateral extremities. The injured worker was alert and oriented x3, muscle tone was normal without clonus. Deep tendon reflexes were symmetrical and normal in the bilateral upper extremities. Sensation to light touch was intact in the bilateral upper extremities. There was a positive Tinel's median on the right side. There was no tenderness to palpation to the trapezius or cervical paraspinal muscles. There was no plan of care documented on the progress note. No rationale or Request for Authorization form was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Services: Venopro (DVT Device): 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) Knee and Leg Chapter, Venous Thrombosis.

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

Decision rationale: The request for associated surgical service DVT device is not medically necessary. The Official Disability Guidelines recommend DVT machines when patients are at high risk for developing venous thrombosis and providing prophylactic measures, such as consideration for anticoagulation therapy. However, it is unclear how the provider feels the use of a DVT device would be medically necessary for the injured worker. There was no indication of the injured worker having surgery, nor was there an indication of a scheduled surgery. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

Associated Surgical Services: Interferential Unit (IF) rental for one to two months: 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) Pain Chapter, Interferential Current Stimulation (ICS).

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

Decision rationale: The request for associated surgical service interferential unit rental for 1 or 2 months is not medically necessary. The Official Disability Guidelines state that IFC units are under study for osteoarthritis and recovery post knee surgery. They are not recommended for chronic pain or low back problems. After knee surgery, home interferential current therapy may help reduce pain, pain medication taken, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. The submitted documentation did not indicate that the injured worker was scheduled or had undergone any type of surgery. Additionally, there was no rationale submitted for review to warrant the request. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.