

Case Number:	CM15-0101457		
Date Assigned:	06/03/2015	Date of Injury:	10/16/2014
Decision Date:	07/09/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/27/2015

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: 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 25 year old male, who sustained an industrial injury on October 16, 2014, incurring right hand injuries. He was diagnosed with a complex right hand open wound with pressurized water infiltration, right elbow internal derangement and right hand tenosynovitis. He underwent a surgical exploration of the right hand injury and repair of the torn ligament. Treatment included antibiotics, anti-inflammatory drugs, physical therapy, orthopedic referral and work modifications. Magnetic Resonance Imaging of the right wrist open wound revealed ligament tears. Currently, the injured worker complained of constant right hand, wrist, and elbow burning pain, throbbing and numbness. The treatment plan that was requested for authorization included a transcutaneous electrical stimulation unit and cold/heat therapy unit rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS/EMS Unit Rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, nor is there any documented short-term or long-term goals of treatment with the TENS unit. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the therapy treatment already rendered. The TENS/EMS Unit Rental is not medically necessary or appropriate.

Cold/Heat Therapy Unit Rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Chapter-Forearm, Wrist, and Hand, Cold Packs, page 157.

Decision rationale: Regarding Cold therapy, guidelines state it is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. Submitted reports have not provided adequate documentation, risk factors, or comorbidities to support for the request beyond guidelines, criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines. MTUS Guidelines is silent on the specific use of cold/heat care, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day in the post-operative period as efficacy has not been proven after. The Cold/Heat Therapy Unit Rental is not medically necessary or appropriate.