

Case Number:	CM15-0204801		
Date Assigned:	10/21/2015	Date of Injury:	01/01/2013
Decision Date:	12/09/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	10/19/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

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 41 year old male, who sustained an industrial injury on 1-1-2013. Medical records indicate the worker is undergoing treatment for right wrist avascular necrosis. An Agreed Medical Evaluator report dated 8-11-2015, reported the injured worker complained of right hand pain rated 5 out of 10. Physical examination revealed right hand grip measurements of 40-36-36. Progress notes from 4-17-2015 and 5-22-2015 reported the injured worker complained of low back pain with no complaints of wrist pain but the physician noted right wrist tenderness and decreased right wrist range of motion. The patient had positive SLR and Tinel and Finkelstein sign. Right hand magnetic resonance imaging from 8-5-2014 was within normal limits. Treatment to date has included physical therapy and medication management. The medication list include Naproxen, gabapentin, Cyclobenzaprine and Protonix. The patient had X-ray of the lumbar spine and cervical spine that revealed degenerative changes with spur formation. Patient had received lumbar ESI for this injury. Per the note dated 8/11/15 the patient had complaints of pain in neck, back, shoulder and wrist. The pain was alleviated with rest PT, and medication. Physical examination of the lumbar spine revealed tenderness on palpation, limited range of motion, muscle spasm and negative SLR. The patient was hospitalized in 2010 for stomach issues. On review of systems, the patient did not have any complaints of gastrointestinal tract on 4/17/15. A recent detailed clinical examination of the gastrointestinal tract was not specified in the records provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Solace Stim Unit for the right wrist -unknown rental or purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim). Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist and Hand, Electrical stimulators.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) is "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." Per the cited guideline "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." Per the records provided, the indications listed above were not specified in the records provided. The records provided do not specify a response to conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts for this injury. The patient had received an unspecified number of PT visits for this injury. In addition it is noted in the records that the pain was alleviated with rest PT, and medication per the note dated 8/11/15. The medical necessity of the request for Solace Stim Unit for the right wrist -unknown rental or purchase is not fully established in this patient.