

Case Number:	CM14-0118642		
Date Assigned:	08/06/2014	Date of Injury:	05/08/2013
Decision Date:	10/08/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/25/2014

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 and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 63-year-old individual was reportedly injured on 5/8/2013. The mechanism of injury was noted as a lifting injury. The most recent progress note, dated 7/14/2014, indicated that there were ongoing complaints of neck pain and left upper extremity pain. The physical examination demonstrated cervical spine had positive tenderness to palpation and spasm to the bilateral paraspinal muscles, positive occipital muscles, suboccipital muscles, bilateral trapezius muscles, and scapula muscles. There was also decreased range of motion, positive compression test, left shoulder and bicep deformity and tenderness to palpation to anterior/posterior/lateral bicep, deltoid, rotator cuff, and acromion process. There were positive Neers, Codman's, and supraspinatus tests. There was decreased motor strength. Decreased sensation was at the left anterior and lateral shoulder, arm, lateral forearm and hand. No recent diagnostic studies are available for review. Previous treatment included physical therapy, medications, and conservative treatment. A request had been made for interferential unit and hot/cold unit and was not certified in the pre-authorization process on 7/3/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

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

Decision rationale: The California MTUS Guidelines do not support interferential therapy as an isolated intervention. The guidelines will support a one-month trial in conjunction with physical therapy, an exercise program, and a return to work plan if chronic pain is ineffectively controlled with pain medications or side effects to those medications. Review of the available medical records, fails to document any of the criteria required for an IF unit one-month trial. As such, this request for the use of an inferential unit is not medically necessary.

Hot and Cold Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers Compensation Neck & Upper Back Procedure Summary, Shoulder Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC/ODG Integrated Treatment/Disability Duration Guidelines; Shoulder (Acute & Chronic) - Continuous Flow Cryotherapy - (updated 7/29/14).

Decision rationale: Hot And Cold unit is recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. After review of the medical records provided, the patient is not in an acute postoperative status. Therefore, this request is deemed not medically necessary.