MAXIMUS Federal Services

Case Number:	CM14-0124562		
Date Assigned:	08/08/2014	Date of Injury:	10/06/2011
Decision Date:	10/09/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	08/06/2014

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 41-year-old individual was reportedly injured on October 6, 2011 due to pulling a hose at work. The most recent progress note, dated July 21, 2014, indicated that there were ongoing complaints of neck and back pain, as well as right shoulder and elbow pain. The physical examination demonstrated a 5'9", 220 pound individual who was borderline hypertensive (137/36). There was tenderness to palpation of the paraspinous musculature of the cervical spine. Some muscle spasm was noted as well as a decreased range of motion. Right shoulder range of motion noted a healed surgical incision with flexion limited to 120 degrees and abduction at 100 degrees. A positive Tinel's sign was noted at the right elbow and wrist. There was tenderness to palpation of the lumbar spine with a decreased range of motion and numbness to the lateral aspect of the right lower extremity. Diagnostic imaging studies were requested and no results were reported. Previous treatment included shoulder surgery, conservative care, multiple medications and home exercise physical therapy protocol. A request had been made for a heat/cold therapy unit and ortho stimulator unit and was not certified in the pre-authorization process on July 14, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/ Cold Therapy Unit- Lumbar Spine: 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 162, 300.

Decision rationale: When considering the date of injury, the most recent physical examination offered and the lack of competent, objective and independently confirmable medical evidence to suggest any efficacy, utility or benefit from such intervention, there is no clear data presented to support this intervention. As such, when noting the data presented, this request is not medically necessary.

Ortho Stimulator Unit - Lumbar Spine: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

Decision rationale: As noted in the MTUS guidelines, there is no recommendation to support transcutaneous nerve stimulation as a treatment modality. Therefore, when noting the lack of any efficacy or positive long-term outcomes, there is no clear clinical indication of the medical necessity of this device.