

Case Number:	CM14-0144689		
Date Assigned:	09/12/2014	Date of Injury:	01/04/2011
Decision Date:	10/14/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/08/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in California. 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 determination

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 53-year-old male who reported an injury on 01/04/2011. The mechanism of injury was not indicated. The injured worker has diagnoses of left shoulder impingement, thoracic sprain and strain and a cervical sprain and strain. Past medical treatment was not provided in medical records. Diagnostic studies were not provided in the medical records. Surgical history included a carpal tunnel release. A urine drug screen was performed on 12/23/2013, which was consistent with the injured worker's prescribed medication regimen. The clinical note dated 08/12/2014 was handwritten and difficult to decipher. It appeared to show the injured worker complained of upper and mid back pain and had mild pain and decreased range of motion. Medications were not provided in the medical record documentation. The treatment plan included a request for decision for IF unit purchase and supplies and for hot and cold compress unit purchase with pad and wrap. The rationale for the request was not provided. The Request for Authorization form was not provided in the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF unit purchase and supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

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

Decision rationale: The injured worker complained of upper and mid back pain. The California MTUS guidelines state interferential current stimulation 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. The guidelines state use of interferential stimulation may be appropriate if it has been documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine. There is lack of documentation indicating the injured worker had tried and failed on previous conservative therapy. There is lack of documentation indicating the injured worker has significant loss of the ability to function independently resulting from his pain. There is no indication as to the efficacy of the unit when applied by the physician. In addition, the submitted request does not specify the frequency, duration, or site of treatment. Therefore, the request for the decision for IF unit purchase and supplies is not medically necessary.

Hot/cold compression unit purchase w/pad/wrap: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 263-264. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome, Continuous cold therapy (CCT).

Decision rationale: The CA MTUS/ACOEM Guidelines recommend at home local applications of cold packs for the first few days of acute complaints; thereafter, applications of heat packs. The Official Disability Guidelines recommend continuous cold therapy only as an option in the postoperative setting. Postoperative use generally should be no more than 7 days, including home use. The medical records provided indicate the injured worker had a carpal tunnel release over one year prior. The rationale for the request was not provided. There is lack of documentation indicating the injured worker had tried and failed on previous therapy. The guidelines only recommend continuous cold therapy in the postoperative setting. In addition, the submitted request does not specify the frequency, duration, or site of treatment. Therefore, the request for Hot/cold compression unit purchase w/pad/wrap is not medically necessary.