MAXIMUS Federal Services

Case Number:	CM14-0046726		
Date Assigned:	07/02/2014	Date of Injury:	07/23/2011
Decision Date:	08/12/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/14/2014

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 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 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 injured worker is a 41-year-old male who reported an injury after falling off a ladder on 7/23/11. The clinical note dated 3/19/14 indicated diagnoses of rule out facial nerve, orthopedic diagnoses, tension type headache, lumbar sprain, thoracic or lumbosacral neuritis or radiculitis, spinal stenosis, sprain of shoulder and upper arm, disorders of bursae and tendons in shoulder region, rotator cuff sprain, wrist sprain, adjustment reaction with prolonged depressive reaction, and abnormal weight gain. The injured worker reported pain in the left wrist and reported facial twitching on the right side of the face. The injured worker reported fatigue and blurred vision. The injured worker reported stress, loss of sleep, and reported pain was 3/10. On physical examination, the provider noted the injured worker had a sleep disorder and stress secondary to pain and difficulty breathing at night. The injured worker's prior treatments included medication management. The injured worker's medication regimen included naproxen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional capacity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 125. Decision based on Non-MTUS Citation ACOEM: Chapter 7, page 138.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The California MTUS/ ACOEM guidelines state that it may be necessary to obtain a more precise delineation of patient capabilities than is available from routine physical examination; under some circumstances, this can best be done by ordering a functional capacity evaluation of the injured worker. The Official Disability Guidelines recommend a functional capacity evaluation may be used prior to admission to a work hardening program with preference for assessment tailored to a specific task or job. The functional capacity evaluation is not recommended as routine use, as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. It was not indicated as to how the functional capacity evaluation would aid the provider in the injured worker's treatment plan and goals. In addition, there was a lack of information upon physical exam and a lack of documentation of other treatments the injured worker underwent previously and the measures of progress with the prior treatments. Moreover, the requesting physician's rationale for the request was not indicated. Additionally, it was not indicated as to whether a work hardening program was recommended. Therefore, the request is not medically necessary.

Interferential unit: Upheld

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

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

Decision rationale: The California MTUS guidelines do not recommend the use of interferential current stimulation (ICS) 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. There is a lack of documentation including an adequate and complete physical exam demonstrating the injured worker had decreased functional ability, decreased range of motion, and decreased strength or flexibility. In addition, the provider did not indicate a rationale for the request. Moreover, the provider did not indicate a body part for the request. Additionally, the request did not indicate a time frame for the interferential unit. Therefore, the request is not medically necessary.

Hot/cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Treatment section for the low back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy 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. Complications related to cryotherapy (i.e., frostbite) are extremely rare, but can be devastating. The documentation submitted did not indicate the injured worker was a candidate for surgery. In addition, the provider did not indicate a rationale for the request. Moreover, the request did not indicate a time frame or a body part for the unit. Therefore, the request is not medically necessary.