

Case Number:	CM14-0088881		
Date Assigned:	07/23/2014	Date of Injury:	10/14/2013
Decision Date:	12/03/2014	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	06/13/2014

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 Preventive 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 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:

According to the records made available for review, this is a 35-year-old female with a 10/14/13 date of injury. At the time (6/2/14) of request for authorization for IF Unit-purchase with batteries and electrodes and bilateral cock-up wrist splints for purchase, there is documentation of subjective (on-and-off upper back pain, radiation to the shoulder, associated numbness and tingling sensation, bilateral arms pain, right elbow pain, bilateral hand pain, associated numbness and tingling) and objective (tenderness to palpation to the cervical spine, upper trapezius muscles, rhomboids, and rotator cuffs bilaterally, positive shoulder impingement, tenderness to palpation of the right lateral epicondyle, and positive Tinel's and Phalen's bilaterally, and positive McMurray on the left knee) findings, current diagnoses (cervical spine strain/sprain, right shoulder impingement, left shoulder impingement, right lateral epicondylitis, right carpal tunnel syndrome, left carpal tunnel syndrome and left knee strain/sprain), and treatment to date (medications (ibuprofen)). Regarding the requested IF Unit-purchase with batteries and electrodes, there is no documentation that the IF unit will be used in conjunction with additional recommended treatments, including return to work, and limited evidence of improvement on recommended treatments alone.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit-purchase with batteries and electrodes: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that 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. Within the medical information available for review, there is documentation of diagnoses of cervical spine strain/sprain, right shoulder impingement, left shoulder impingement, right lateral epicondylitis, right carpal tunnel syndrome, left carpal tunnel syndrome and left knee strain/sprain. In addition, there is documentation that the IF unit will be used in conjunction with recommended treatments, including exercise and medications. However, there is no documentation that the IF unit will be used in conjunction with additional recommended treatments, including return to work, and limited evidence of improvement on recommended treatments alone. Therefore, based on guidelines and a review of the evidence the request for IF Unit purchase with batteries and electrodes is not medically necessary.

Bilateral cock-up wrist splints for purchase: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which a wrist brace is indicated (such as: acute, subacute, or chronic CTS; moderate or severe acute or subacute wrist sprains; acute, subacute, or chronic ulnar nerve compression at the wrist; acute, subacute, or chronic radial nerve neuropathy; scaphoid tubercle fractures; acute flares or chronic hand osteoarthritis; Colles' fracture; or select cases (i.e., patients who decline injection) of acute, subacute, or chronic flexor tendon entrapment), as criteria necessary to support the medical necessity of wrist splinting. Within the medical information available for review, there is documentation of diagnoses of cervical spine strain/sprain, right shoulder impingement, left shoulder impingement, right lateral epicondylitis, right carpal tunnel syndrome, left carpal tunnel syndrome and left knee strain/sprain. In addition, there is documentation of a condition/diagnosis (with supportive subjective/objective findings) for which a wrist brace is indicated (such as: CTS). Therefore, based on guidelines and a review of the evidence, the request for bilateral cock-up wrist splints for purchase is medically necessary.

