MAXIMUS Federal Services

Case Number:	CM15-0009716		
Date Assigned:	01/27/2015	Date of Injury:	08/23/2010
Decision Date:	03/23/2015	UR Denial Date:	01/12/2015
Priority:	Standard	Application Received:	01/16/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 female who reported an injury on 08/23/2010. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of carpal tunnel syndrome. Past medical treatment consisted of a cold therapy unit, hot/cold pads, and interferential current stimulation. It was noted on 12/15/2014 that the injured worker complained of shoulder and bilateral arm pain. The injured worker rated the pain at 7/10. Physical examination findings were not legible. The progress note dated 12/10/2014 indicated that the injured worker's pain was the same. Physical examination noted that there was tenderness to palpation of the bilateral wrists. The medical treatment plan was for the injured worker to continue with interferential stimulation. A rationale was not submitted for review. A Request for Authorization form was submitted on 01/05/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interspec IF II and monthly supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

Decision rationale: The request for interferential stimulation (IF) 2 and monthly supplies is not medically necessary. The California MTUS Guidelines do not recommend stim care units as an isolated intervention. There is no quality evidence of effectiveness, except in conjunction with recommended treatments, including return to work, exercise, and medications. It may be recommended if pain is ineffectively controlled by medications, medication intolerance, history of substance abuse, significant pain from postoperative conditions which limit the ability to perform exercise programs/physical therapy treatment, or unresponsiveness to conservative measures. The submitted documentation did not provide pertinent information regarding the outcomes of the unit used. The efficacy of the medication was unclear. Additionally, there was no indication of the injured worker participating in any exercise programs/physical therapy treatments, nor was there any indication of medication therapy. Furthermore, the documentation that was provided did not reflect diminished effectiveness of medications, a history of substance abuse, or any postoperative conditions which would limit the injured worker's ability to perform exercise programs/physical therapy treatments. The requesting physician did not include an adequate and complete assessment of the injured worker's objective functional condition which would demonstrate deficits needing to be addressed as well as establish a baseline by which to assess objective functional improvement over the course of therapy. Furthermore, the request as submitted did not specify what extremity was going to be using the unit. Given the above and the submitted documentation, the request would not be indicated. As such, the request is not medically necessary.

Cold therapy unit, hot/cold pad, assy straps 16"/48": Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ICS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee, continuous flow cryotherapy.

Decision rationale: The request for a cold therapy unit, hot/cold pads, assy straps is not medically necessary. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery for up to 7 days, including home use. The request for a cold therapy unit, hot/cold, exceeds the recommendations of the guidelines. It is unclear if the request was for the purchase or rental of the unit and the medical documents provided did not indicate a medical need for a cryotherapy unit that would fall within the guideline limitations, such as surgery. Given that there were no other significant factors provided to justify the request, the request would not be indicated. As such, the request is not medically necessary.