

Case Number:	CM15-0110579		
Date Assigned:	06/17/2015	Date of Injury:	01/09/1998
Decision Date:	07/15/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/08/2015

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 44 year old female who sustained an industrial injury on 01/09/98. Initial complaints and diagnoses are not available. Treatments to date include medications. Diagnostic studies are not addressed. Current complaints include unspecified neck, and upper extremity symptoms. Current diagnoses include chronic cervical spondylosis with cervical radiculopathy, bilateral shoulder impingement syndrome, and bilateral de Quervain's syndrome /carpal tunnel syndrome. In a progress note dated 05/27/145 the treating provider reports the plan of care as medications including Anaprox and Prilosec, as well as a surgical consultation, and Ortho Stim unit with supplies and a Thermophone heating pad. The requested treatments include a stimulator unit with electrodes and a large thermophone heating pad.

IMR ISSUES, DECISIONS AND RATIONALES

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

Stim Unit and Supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain 114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, interferential stimulation is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of transcutaneous stim unit include trial in conjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. It appears the patient has received extensive conservative treatment to include medications and exercise which is documented to control his symptoms. There is no documentation on the short-term or long-term goals of treatment with the interferential unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the stim unit purchase as there is no documented failed trial of TENS. There is no evidence for change in work status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from any transcutaneous stimulation therapy already rendered. The Stim Unit and Supplies is not medically necessary and appropriate.

Thermophore Heating Pad, Large: 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 ODG, Cryotherapy/Cold & Heat Packs, pages 381-382.

Decision rationale: Regarding Hot/Cold therapy, guidelines state it is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The request for authorization does not provide supporting documentation for purchase beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines. The requests for the purchase of the Thermophore Pad do not meet the requirements for medical necessity. MTUS Guidelines is silent on specific use of hot/cold compression therapy, but does recommend standard hot/cold pack with exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. There is no history of surgery noted. The Thermophore Heating Pad, Large is not medically necessary and appropriate.