

Case Number:	CM15-0069656		
Date Assigned:	04/17/2015	Date of Injury:	09/02/2011
Decision Date:	05/18/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	04/13/2015

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: Preventive Medicine, Occupational Medicine

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 male, who sustained an industrial injury on 9/02/2011, while employed as a fabricator. He reported continuous trauma from lifting, carrying, pushing, pulling, prolonged standing, walking, bending, kneeling, stooping, grasping, and other activities as a result of work activities. The injured worker was diagnosed as having cervical musculoligamentous sprain/strain with radiculitis, thoracic musculoligamentous sprain/strain, lumbosacral musculoligamentous sprain/strain with radiculitis, left shoulder sprain/strain, left elbow sprain/strain, left wrist sprain/strain, situational depression, and sleep disturbance secondary to pain. Treatment to date has included diagnostics, chiropractic, physical therapy (for 2 months per Agreed Medical Evaluation dated 12/17/2014), and medications. Currently, the injured worker complains of headaches, neck pain, back pain with radiation to both legs, left shoulder and arm pain, left elbow pain, left wrist pain, bilateral knee pain, anxiety, depression, and sleeping problems. The treatment plan included Mobic, lumbosacral brace, left wrist brace, interferential unit, and hot/cold unit. Physical therapy evaluation and treatment (2x6) was also recommended for the cervical, thoracic, and lumbar spines, along with the left shoulder, left elbow, and left wrist. Work status was total temporary disability. Progress notes from prior physical therapy sessions were not submitted m but there is a history of multiple prior sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 120.

Decision rationale: Due to the questionable benefit from Interferential Units (IF), Guidelines have very specific criteria regarding its use. Prior to a 1 month trial, successful application by a medical professional is recommended to demonstrate at least temporary pain relief. Prior to purchase a 1 month home rental is recommended with specific documentation of benefits. These Guideline conditions have not been met and there are no unusual circumstances to justify an exception to Guidelines. The Interferential Unit is not medically necessary.

Hot & Cold Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Cold and Heat, Shoulder - Continuous Cold Therapy, Knee - Continuous Cold Therapy.

Decision rationale: MTUS Guidelines do not address this issue. ODG Guidelines address this issue in detail. A continuous cool/heating unit is only recommended for postoperative use for up to 7 days. This type of unit is not recommended for the management of chronic pain. Heat but not cold therapy is recommended for low back pain, however heat wraps are recommended under these circumstances. There is no Guidelines support for a hold & cold unit under these circumstances. The Hot & Cold unit is not medically necessary.

12 Physical Therapy sessions to the Cervical, Thoracic, Lumbar Spine and Left Shoulder (2x6): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy; Neck Chapter, Physical Therapy; Shoulder Chapter, Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: MTUS Guidelines recommended up to 8-10 sessions of physical therapy as adequate for nearly all chronic painful conditions. It is expected that therapy will be utilized to set up a safe and appropriate self-protective and activity program. It is well documented that this individual has had numerous therapy sessions in the past, yet there is little evidence of benefits

for follow through. A few sessions to renew a home program may be reasonable, but the request for 12 sessions to the cervical, thoracic, lumbar spine and left shoulder is not supported by Guidelines and is not medically necessary.