

Case Number:	CM13-0028487		
Date Assigned:	02/20/2014	Date of Injury:	12/16/2009
Decision Date:	11/07/2014	UR Denial Date:	09/04/2013
Priority:	Standard	Application Received:	09/24/2013

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 Family Medicine, and is licensed to practice in North Carolina. 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 patient is a 61-year-old with a reported date of injury of 12/16/2009. The patient has the diagnoses of chronic neck pain; status post left shoulder arthroscopy, status post right carpal tunnel release, left carpal tunnel syndrome and stomach pain. Previous treatment modalities have included physical therapy and left carpal tunnel injection. Per the most recent progress notes provided for review by the primary treating physician dated 08/27/2014, the patient had complaints of increased neck pain, shoulder pain and bilateral wrist pain. The physical exam noted cervical spine spasm with painful range of motion and paraspinal tenderness. There was a positive Phalen's test on the left wrist. Treatment plan recommendations included left shoulder forward flexion passive exercise, aquatic therapy for the left shoulder, Naproxen and request for left wrist carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF UNIT/COLD UNIT FOR THREE (3) WEEKS (POST OP): 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 interferential current stimulators Page(s): 118-120.

Decision rationale: The California chronic pain medical treatment guidelines section interferential therapy states: While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. Per the California MTUS criteria for IF therapy, one criterion is when significant pain form postoperative conditions limits the ability to perform exercise programs/physical therapy treatment. The request has been made for left carpal tunnel release. However the procedure has not been performed and there is no way to tell if the patient would not be able to perform post-operative exercise programs/physical therapy due to significant pain. Therefore the request is not medically necessary.

IF x 30 DAYS TRIAL: 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 interferentail current stimulators Page(s): 118-120.

Decision rationale: The California chronic pain medical treatment guidelines section interferential therapy states: While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. The provided documentation states the patient has failed injection therapy and physical therapy. Though he patient does report increased pain subjectively in the progress reports, there is no documentation of failure of adequate trial of first-line medication therapies for the patient's pain. Therefore the request does not meet the criteria and is not medically necessary.

THERMO-COOL COMPRESSION x 60 TRIAL (AFTER SURGERY): Upheld

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

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

Decision rationale: The ACOEM and the California MTUS do not specifically address the requested services. Per the Official Disability Guidelines, continuous flow cryotherapy is recommended as an option after surgery but not for non-surgical treatment. Postoperative use may be up to 7 days including home use. There is no documentation why this device would be needed over a cryotherapy unit. There is also no indication on what exactly the recommended length of time has been requested for the use of these services and thus if they comply with criteria as set forth in the ODG. Therefore the request is not medically necessary.