

Case Number:	CM14-0078850		
Date Assigned:	07/18/2014	Date of Injury:	04/22/2014
Decision Date:	11/03/2015	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	05/29/2014

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. 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: Texas, Florida
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 sustained industrial injuries on April 22, 2014. Diagnosis included left knee contusion, then subsequently, she also reported the development of head, back, ankle, and right hand pain and was diagnosed with right hand contusion with sprain or strain, and ankle sprain. Documented treatment included hot-cold therapy pack, heat therapy pad, hinged knee-brace, quad cane, wrist-wrap, Tylenol, Nabumetone, Biofreeze, Relafen, ice, heat, and she was provided with home exercises, but she continued to report back spasms, right wrist swelling with decreased strength and range of motion, left knee swelling and weakness, and back pain. The treating physician's plan of care on May 1, 2014 included a right wrist-thumb spica brace, lumbosacral brace, left knee sleeve, interferential unit, and a hot-cold therapy unit, all of which were denied on May 15, 2014. She was placed on work restrictions at that time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Wrist-thumb Spica Brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Work-Relatedness, Work Activities, and Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Upper Extremities, DME.

Decision rationale: The CA MTUS and the ODG guidelines recommend that Durable Medical Equipment (DME) can be utilized increase mobility, physical function and comfort in patients who would otherwise be unable to accomplish these goals without DME. There is lack of guidelines support for the utilization of DME without objective findings of functional deficit. The utilization of most DME have not been shown to be beneficial past the acute injury phase. The records did not show subjective or objective findings consistent with significant functional limitation requiring the use of DME. The patient had already utilized a wrist wrap without functional improvement. The criteria for the use of Right Wrist -thumb Spica Brace was not met. Therefore, the request is not medically necessary.

Left Knee Sleeve: Upheld

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

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Work-Relatedness, Activity Alteration, and Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Knee.

Decision rationale: The CA MTUS and the ODG guidelines recommend that Durable Medical Equipment (DME) can be utilized increase mobility, physical function and comfort in patients who would otherwise be unable to accomplish these goals without DME. There is lack of guidelines support for the utilization of DME without objective findings of functional deficit. The utilization of most DME have not been shown to be beneficial past the acute injury phase. The records did not show subjective or objective findings consistent with significant functional limitation requiring the use of DME. The records indicate that the patient had utilized a hinge knee brace without significant functional improvement. The criteria for the use of left knee sleeve was not met. Therefore, the request is not medically necessary.

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Electrostimulation therapy, Interferential Stimulation.

Decision rationale: The CA MTUS and the ODG guidelines recommend that electrostimulation therapy can be utilized for the treatment of chronic musculoskeletal pain. The use of electrical simulation therapy such as TENS unit can be associated with pain relief, reduction in medication utilization and functional restoration. There is lack of guidelines support for the chronic utilization of Interferential Unit after the supervised Physical Therapy treatments. There is no data to support that the chronic utilization of Interferential Unit is associated with sustained pain relief or functional restoration. The criteria for the use of Interferential Unit was not met. Therefore, the request is not medically necessary.

Hot/cold therapy unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Cold Therapy.

Decision rationale: The CA MTUS and the ODG guidelines recommend that Cold Therapy can be utilized for treatment after acute injury and in the post-operative period. The use of hot/cold therapy can be associated with decrease in tissue swelling, pain relief, increase in range of motion and functional restoration. There is lack of guidelines support for the utilization of hot/cold therapy after 1 week following tissue damage. The records indicate that the time of request for ice/cold therapy unit had exceeded the 1-week post injury period. The patient had already completed the use of hot/cold therapy in the first 1 week following the injury. The criteria for the use of Hot /Cold therapy unit was not met. Therefore, the request is not medically necessary.

Lumbosacral Brace: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Work-Relatedness, Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Low Back, DME - Back Brace.

Decision rationale: The CA MTUS and the ODG guidelines recommend that Durable Medical Equipment (DME) can be utilized increase mobility, physical function and comfort in patients who would otherwise be unable to accomplish these goals without DME. There is lack of guidelines support for the utilization of DME without objective findings of functional deficit. The utilization of most DME has not been shown to be beneficial past the acute injury phase. The records did not show subjective or objective findings consistent with significant functional limitation requiring the use of lumbar brace. The guidelines noted lack of functional improvement with utilization of a back brace pass the acute injury period. The criteria for the use of Lumbosacral brace was not met. Therefore, the request is not medically necessary.