

<b>Case Number:</b>	CM13-0025436		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	03/06/2012
<b>Decision Date:</b>	01/29/2014	<b>UR Denial Date:</b>	09/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Pulmonary Diseases and is licensed to practice in California. 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 physician 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 63 year old male who reported an injury on 03/06/2012. The mechanism of injury was loading cargo bags of mail when he developed back and leg pain. The patient diagnoses included lumbago, lumbar strain/sprain, and sprain/strain of sacroiliac. Review of the medical record reported the patient has had an MRI of the lumbar spine that revealed multiple 2 to 3mm disc bulges at multiple levels in the lumbar spine. As recent as 12/05/2013 the patient continued to have daily low back pain and stiffness with right-sided muscle spasms, and stiffness with occasional radiating numbness into the right thigh and knee. The patient rated his pain as 6 on a 10 scale at its best and 8-9 out of 10 at its worse. Physical assessment revealed restricted range of motion to all planes of the lumbar spine. Right straight leg raise was positive with noted numbness on the thigh. There was pain with palpation noted at the middle aspect of the lumbar spine with associated spasms, and pain over the lumbar (L) five to sacral (S) one area and right sacroiliac joint.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**. Heating pad:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Low Back. MTUS/ACOEM guidelines 2004, second edition, chapter 12, page 300.

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

**Decision rationale:** Official Disability Guidelines states combining continuous low-level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control. (Mayer-Spine, 2005) There is moderate evidence that heat wrap therapy provides a small short-term reduction in pain and disability in acute and sub-acute low-back pain, and that the addition of exercise further reduces pain and improves function. There is no clinical documentation of the patient currently participating in exercise or activity programs. The clinical information provided in the medical record does not discuss any home exercise programs. Per the Official Disability Guidelines heating therapy works best in conjunction with exercise. As such the request for heating pad is non-certified.

**Urine toxicology screening:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Low Back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**Decision rationale:** California MTUS American College of Occupational and Environmental Medicine (ACOEM) does not address urine drug screen in depth, it is mentioned in ongoing management of opioid therapy. Per California MTUS urine drug screens are used with issues of abuse, addiction or if there is poor pain control, and they are a part of the contract signed when opioid pain management agreement is initiated. There is no clinical documentation of any current pain medications, including opioids being taken by the patient. Without clinical information stating the patient is on opioid therapy, there is no medical necessity proven for urine toxicology screen. As such, the request for urine toxicology screening is non-certified.

**Electrical muscle stimulation unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrical stimulation Page(s): 114-120. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** California MTUS states transcutaneous electrotherapy is not recommended as a primary treatment modality. A trial of home based transcutaneous electrotherapy could be considered if used with a program of evidence based functional restoration. There is no clinical

documentation suggestive that the patient is currently participating in any program of evidence based functional restoration at the time of the request. As such, the request for the electrical muscle stimulation unit is non-certified.