

Case Number:	CM13-0032232		
Date Assigned:	12/04/2013	Date of Injury:	09/25/2006
Decision Date:	02/18/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	10/07/2013

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 Family Practice and is licensed to practice in Texas. 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 62 year old female who sustained a work related injury on 09/25/2006. The patient's diagnoses include radiculitis, complex regional pain syndrome, myalgia, depression, chronic pain, left knee pain, insomnia, and right cubital tunnel syndrome. Subjectively, the patient reported complaints of low back pain with radiation into the bilateral lower extremities and neck pain with radiation into the bilateral upper extremities to the level of the hand, right greater than the left. The patient reported the neck pain was associated with tingling and numbness in the upper extremity. The patient rated her pain 7/10 to 9/10 with medication and 8/10 to 9/10 without medications. Objectively, the patient had decreased range of motion, tenderness, and swelling of the right wrist and hand. Request for authorization for the following were made, a Tempur-Pedic mattress, a motorized scooter and a TENS unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS for purchase for cervical and low back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-115.

Decision rationale: CA MTUS guidelines indicate that TENS units are "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration in cases of neuropathic pain, Phantom limb pain and CRPS II, spasticity, and multiple sclerosis." The clinical provided documented a diagnosis of complex regional pain syndrome. The clinical information submitted for review indicated the patient was authorized a TENS unit trial, but there is lack of documentation of the patient having undergone the trial or the efficacy of the trial. Given the above, the request is not supported. As such, the request for TENS for purchase for cervical and low back pain is non-certified.

Purchase of orthopedic mattress (include ortho bed) for cervical and low back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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 Chapter, Mattress selection.

Decision rationale: Official Disability Guidelines state, "There are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain, and mattress selection is subjective and depends on personal preference and individual factors." The requested durable medical equipment is a convenience treatment and is not a medical necessity for the treatment of back pain. Given the lack of recommendation by guidelines, the request is not supported. As such, the request for purchase of orthopedic mattress (include ortho bed) for cervical and low back pain is non-certified.

Purchase of electric scooter for cervical and low back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99.

Decision rationale: CA MTUS guidelines do not recommend the use of power mobility devices "if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair." The clinical information submitted for review lacks objective documentation of decreased motor strength or the patient's inability to propel a manual wheelchair. As such, the request for purchase of electric scooter for cervical and low back pain is non-certified.