MAXIMUS Federal Services

Case Number:	CM13-0035297		
Date Assigned:	12/13/2013	Date of Injury:	05/20/2009
Decision Date:	04/25/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/17/2013

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 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 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 42-year-old female with a diagnosis of cervical sprain/strain, multiple cervical disc herniations, cervical neuritis of bilateral upper extremities, cervical radiculitis/radiculopathy, multiple lumbar disc herniations, lumbar radiculitis, and radiculitis/radiculopathy of the left lower extremity, lumbar paraspinal muscle spasm, and sacroiliitis of left sacroiliac joint. The patient was seen on November 04, 2013 for a follow-up appointment. The patient was experiencing pain over the left buttock radiating into the posterior and lateral aspect of left thigh, with numbness and tingling progressively increasing in severity. The physician noted the patient did receive 75% improvement after the second left sacroiliac joint injection performed on July 24, 2013. The patient received improvement with weakness, tingling and numbness in the left Final Determination Letter for IMR Case Number CM13-0035297 3 lower leg. Improvement has sustained for the last 12 weeks. On examination, the physician noted weakness along with tingling and numbness in the left leg, which is progressive, as the patient complains of experiencing severity of these symptoms while climbing stairs, long walks, daily activities and performing home exercise program. Home exercise program consisting of stretching back and legs to improve flexibility. The physician also noted the patient is suffering from severe left sacroiliac joint inflammation with signs and symptoms of radiculitis, radiculopathy to the posterior and lateral aspect of the thigh. Gaenslen's test and Patrick-Fabere test were positive, sacroiliac joint thrust demonstrated severely positive on today's exam

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS UNIT WITH SUPPLIES X30 DAYS FOR THE LOW BACK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tens, Chronic Pain (Transcutaneous Electrical Nerve Stimulation) P.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tens, Chronic Pain (Transcutaneous Electrical Nerve Stimulation) Page(s): 114-115.

Decision rationale: The California MTUS Guidelines does not recommended TENS as a primary treatment modality, for chronic pain. A one (1) 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 for the conditions listed below, which are neuropathic pain and complex regional pain syndrome (CRPS), neuropathic pain, phantom limb pain and CRPS 2, muscle spasticity, and multiple sclerosis. The documentation provided for review did not show that the patient was in an evidence-based functional restoration such as physical therapy at this time. According to the guidelines, this is a requirement as the TENS unit cannot be used solely as the primary treatment modality. Therefore, the request is non-certified.

COLD THERAPY UNIT AND PADS X 30DAYS FOR THE LOW BACK: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 161.

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, COLD/HEAT PACKS

Decision rationale: The California MTUS/ACOEM Practice Guidelines do not address this request. The Official Disability Guidelines does note that cold/heat packs are recommended as an option for acute pain. At-home local application of cold packs first few days of acute complaint, thereafter, application of heat pack or cold pack. The guidelines state basic at-home local application of Final Determination Letter for IMR Case Number CM13-0035297 4 cold/heat packs are appropriate and do not support the need for cold therapy unit and pads for 30 days for the low back at this time. Therefore, the request is non-certified

LSO BACK BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The California MTUS/ACOEM states lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The patient was seen on November 04, 2013, with complaints of pain over the left buttocks radiating into the posterior and lateral aspect of the left thigh with numbness and tingling, progressively increasing in

severity. The patient also suffers from severe left sacroiliac joint inflammation with signs and symptoms of radiculitis and radiculopathy to the posterior and lateral aspect of the thigh. Base on guidelines the request is non-certified.