MAXIMUS Federal Services

Case Number:	CM13-0038425		
Date Assigned:	12/18/2013	Date of Injury:	03/27/2007
Decision Date:	04/28/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/25/2013

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 Physical Medicine and Rehabilitation 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 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:

This is a 38-year-old female patient with a work related injury reported on 03/27/2007 and the mechanism of injury occurred when the patient was assaulted. The injuries were cervical spine ligamentous injury, right cubital tunnel syndrome, right wrist and thumb tendon injury, thoracolumbar spine ligamentous injury, and bilateral sacroiliac joint dysfunction. Other diagnoses included: attention deficit hyperactive disorder, chronic pain with functional recovery, adjustment reaction with functional recovery, bilateral carpal tunnel syndrome, right shoulder degenerative joint disease, right shoulder rotator cuff tendinitis, and TMJ dysfunction. On 09/03/2013, the patient presented for a psychiatric followup and reported low back pain, mid Final Determination Letter for IMR Case Number [redacted] back pain, and neck pain, which had increased since a prior visit. The patient reported having not tried any other new forms of therapy. Medications listed were Prilosec, Synovacin, Ultracet, Abilify, Neurontin, Zyrtec, and Adderall. Activities of daily living had remained unchanged. A urine drug screen was positive for amphetamine.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION Page(s): 114.

Decision rationale: The CA MTUS Guidelines state "Electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Transcutaneous electrotherapy is the most common form of electrotherapy where electrical stimulation is applied to the surface of the skin. 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.". The clinical information submitted for review did not provide evidence of neuropathic pain for which the CA MTUS Guidelines would support and the Guidelines would support a 1 month home trial. A review of records letter, 10/18/2013, failed to provide any prior conservative treatments as well as response to the TENS unit if already applied, as well as duration of use. Given that the documentation also failed to indicate if the TENS unit is for purchase or rental and response to the unit, the request is non-certified.

LUMBAR BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

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

Decision rationale: The CA MTUS/ACOEM Guidelines state "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." The documentation submitted for review failed to provide evidence and clinical information to support the need for the lumbar brace and how it would benefit the patient. Also, the California MTUS/ACOEM Guidelines state that lumbar supports have not been shown to be of any lasting benefit beyond the acute phase. Given that the information submitted for review failed to provide clinical information to support the request as well as not being supported by Guidelines, the request is non-certified.

ARM SLING: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand, Casting versus splints.

Decision rationale: The CA MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines state "Mason type I radial head fractures can be treated with a splint for five to seven days or with a sling as needed for comfort, along with early range-of-motion exercises. Patients

with an olecranon fracture are candidates for nonsurgical treatment if the elbow is stable and the extensor mechanism is intact. Isolated ulnar fractures can usually be managed with a short arm cast or a functional forearm brace." The arm sling per guidelines is more beneficial postoperatively and the documentation submitted for review failed to provide the clinical evidence to support the request for the sling as well as any surgery performed. As such, the request is non-certified.