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| Case Number: | CM13-0070188 | | |
| Date Assigned: | 01/08/2014 | Date of Injury: | 09/15/2009 |
| Decision Date: | 06/20/2014 | UR Denial Date: | 12/06/2013 |
| Priority: | Standard | Application Received: | 12/24/2013 |

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 Occupational Medicine 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:

The patient has submitted a claim for sprain of the lumbar region with radiculopathy, and sacroiliitis associated with an industrial injury date of September 15, 2009. Treatment to date has included nerve block, sacroiliac steroid injection, facet joint rhizotomy, and medications. Medical records from 2012 to 2013 were reviewed showing that patient complained of persistent right axial back pain radiating to her right hip and gluteal area. Physical examination showed moderate right paralumbar, and right sacroiliac joint tenderness; with finger point tenderness to the right lower lumbar facet processes. Lumbar extension resulted to pain. Range of motion of the lumbar spine was restricted. Deep tendon reflexes were normal and symmetric. Slight weakness was noted at the right lower extremity. MRI of the lumbar spine, dated September 17, 2013, revealed no significant interval change since June 1, 2010. Degenerative disc disease at L1 to L2 is minimally greater since the earlier exam. A 2-mm posterior central disc bulge slightly effaces the thecal sac in the midline. There was no peripheral stenosis or nerve root impingement. Ultrasound of the right sacroiliac joint and right piriformis, dated 05/18/2013, revealed prominent inflammatory changes, fibrosis, and sensory nerve thickening; with probable entrapment of the sciatic nerve.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACCUPUNCTURE TREATMENT GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: As stated in the CA MTUS Acupuncture Medical Treatment Guidelines, acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation or to hasten functional recovery. It can be used to reduce pain and inflammation; and increase blood flow, and range of motion. The frequency and duration to produce functional improvement is 3 - 6 treatments, frequency of 1 - 3 times per week, and duration of 1 - 2 months. In this case, the patient has intractable right axial back pain radiating to the right hip and gluteal area. The pain persisted despite use of multiple oral medications, rhizotomy, and steroid injection. The medical necessity for acupuncture has been established, however, it is not reasonable to approve a request that does not specify the body part to be treated and the total number of visits. Therefore, the request for acupuncture is not medically necessary and appropriate.

EVALUATION BY SPINE SURGEON: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES., CHAPTER 7 INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS., PAGE 127.

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

Decision rationale: CA MTUS reference to ACOEM guidelines indicate that a consultation is used to aid diagnosis, prognosis, therapeutic management, determination of medical stability and permanent residual loss and/or examinee's fitness to return to work. The guidelines further state that a surgical consult is indicated if there was activity limitation for more than a month and if exercise programs did not increase range of motion or strengthen the area. In this case, the patient has intractable right axial back pain radiating to the right hip and gluteal area. The rationale given for this request is because of an impression of probable sacroiliac joint dysfunction. The patient underwent intra-articular injection at right sacroiliac joint, however, it only provided temporary benefits. The present diagnosis is further supported by the ultrasound finding of prominent inflammatory changes, fibrosis, and sensory nerve thickening at the right sacroiliac joint and right piriformis; with a probable finding of sciatic nerve entrapment. The medical necessity of this request has been established. Therefore, the request for evaluation by spine surgeon is medically necessary.

PURCHASE OF A MATTRESS: Upheld

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

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, Mattress Selection.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Low Back Section was used instead. It states that there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Mattress selection is subjective and depends on personal preference. A huge variety of mattress includes body-contour foam mattress, hard mattress, medium-firm mattress, etc. In this case, the rationale given for this request is to allow the patient to sleep better and decrease the back pain at night. However, the clinical documentation submitted and reviewed fails to provide exceptional circumstances to support the purchase of a mattress. Furthermore, the guidelines do not recommend its purchase because there are no studies to support its treatment for low back pain. Therefore, the request for purchase of a mattress is not medically necessary.