

Case Number:	CM14-0010739		
Date Assigned:	02/21/2014	Date of Injury:	05/23/2013
Decision Date:	08/04/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	01/27/2014

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 is a 45-year-old male who has submitted a claim for lumbar radiculopathy, and musculoligamentous lumbar sprain/strain associated with an industrial injury date of 05/23/2013. The medical records from 2013 were reviewed. The patient complained of low back pain associated with numbness and tingling sensation at the right lower extremity. The pain was rated 8/10 in severity, and relieved to 4/10 upon medication intake. The aggravating factors included bending, sitting, standing, lifting, and twisting. The physical examination of the lumbar spine showed tenderness, muscle guarding, and decreased range of motion. The straight leg raise was positive at the right. The sensation was diminished at right L5 and S1 dermatomes. The treatment to date has included acupuncture, chiropractic care, physical therapy, and medications such as Norco, and Fexmid.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthostim 4 Interferential Stimulator 4 Quantity Two Month Rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS), H-Wave Stimulation, Neuromuscular Electrical Stimulation Page(s): 114, 117-118, 121.

Decision rationale: Per the website of VQ OrthoCare, the OrthoStim4 combines interferential, TENS, NMS/EMS, and galvanic therapies into one unit to help enhance pain relief, and promote positive outcomes. Multiple claims are made regarding effectiveness without citing specific studies. The CA MTUS Chronic Pain Medical Treatment Guidelines page 114 discusses TENS as opposed to multiple other devices. It does not consistently recommend interferential, NMS, and galvanic electrotherapy (pages 117-118, and 121). In this case, patient has persistent low back pain despite physical therapy, acupuncture, chiropractic care, and medications. However, there is no documentation of a rationale identifying why a combined electrotherapy unit would be required as opposed to a TENS unit. In addition, the details concerning the use of this unit in terms of duration and frequency as well as expected treatment response were not documented. Therefore, the request for orthostim 4 interferential stimulator 4 quantity two-month rental is not medically necessary.

Electrodes Packs Quantity 8 Packs: Upheld

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

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Power Pack Quantity 24: Upheld

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

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Adhesive Remover Towel Mint Quantity 32: Upheld

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

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Shipping and Handling Quantity 1: Upheld

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

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

TT & SS Leadwire Quantity 1: Upheld

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

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Moist Heating Pad Quantity 1: Upheld

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

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: Heat Packs and on the Aetna Clinical Policy Bulletin, Heating Devices chapter.

Decision rationale: The CA MTUS does not address hot/cold wraps specifically. Per the strength of evidence, electric heating pads are medically necessary durable medical equipment (DME) to relieve certain types of pain, decrease joint and soft tissue stiffness, relax muscles, or reduce inflammation. A heating pad is not of proven value to treat pain due to peripheral neuropathy. In this case, patient has a known musculoligamentous strain of the lumbosacral area; hence, a heating pad is an appropriate treatment modality. However, the description of the heating pad is not clear whether this is a passive modality or a motorized unit. Passive modalities are recommended but there is no quality evidence for the use of automated or motorized heating units. There is likewise no documented rationale for this request. Therefore, the request for moist heating pad is not medically necessary.

Pain Management Consult Quantity 1: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations chapter, page 127.

Decision rationale: As stated on page 127 of the California MTUS Chronic Pain Medical Treatment Guidelines Independent Medical Examinations and Consultations chapter, occupational health practitioners may refer to other specialists if the diagnosis is uncertain, or when psychosocial factors are present. In this case, patient had persistent low back pain associated with numbness and tingling sensation at the right lower extremity. Symptoms persisted despite acupuncture, chiropractic care, physical therapy, and intake of medications. The most recent treatment plan includes epidural steroid injection pending assessment by a specialist. Referral to a specialist is warranted at this time for further evaluation and management. Therefore, the request for pain management consult quantity 1 is medically necessary.

Urine Sample Quantity 1: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: Page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that urine drug screens are recommended as an option to assess order use or presence of illegal drugs and as ongoing management for continued opioid use. Screening is recommended randomly at least twice and up to 4 times a year. In this case, current treatment regimen includes opioids and muscle relaxants. However, the most recent urine drug screen from 10/25/2013 was inconsistent with prescribed medications. A confirmatory testing is warranted at this time to assess for drug compliance. Therefore, the request for urine sample quantity 1 is medically necessary.