MAXIMUS Federal Services

| Case Number: | CM14-0089810 | | |
|---|---|---|---|
| Date Assigned: | 08/08/2014 | Date of Injury: | 04/02/2013 |
| Decision Date: | 09/25/2014 | UR Denial Date: | 05/23/2014 |
| Priority: | Standard | Application Received: | 06/13/2014 |

## 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 Physical Medicine and Rehabilitation, and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 41 year-old male was reportedly injured on April 2, 2013. The mechanism of injury is undisclosed. The most recent progress note, dated March 19, 2014 indicated that there were ongoing complaints of cervical, thoracic, and lumbar spine pain. In addition there is bilateral shoulder, bilateral knee, and bilateral wrist complaints. The physical examination demonstrated a 200 pound male to be normotensive and in no acute distress. Diagnostic imaging studies were not reviewed this visit. Previous treatment included physical therapy, multiple medications, trigger point injections and other pain management interventions. A request was made for a lumbar brace, cold therapy unit, exercise kit, inferential unit, psychological evaluation to determine insufficiently stable and secure emotionally to undergo procedure, clearance with internal medicine specialist prior to procedure, lumbar epidural steroid injection, L4 to L5 and was not certified in the preauthorization process on May 23, 2014.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar sacral orthosis:** 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): 301.

**Decision rationale:** ACOEM guidelines do not support the use of lumbar sacral orthosis (LSOs) and other lumbar support devices for the treatment or prevention of low back pain except in cases of specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The claimant is currently not in an acute postoperative setting and there is no documentation of instability or spondylolisthesis. The lack of support for these devices in a subacute and chronic pain setting is based on the decreased activity level and weakness created by the device itself affecting all levels of the lumbar and sacral spine, with further resultant weakness and decreased mobility. Based on the guideline recommendations and the information provided, the requested LSO is not medically necessary.

**Cold therapy unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**Decision rationale:** This type of intervention is indicated after a knee procedure. The handwritten progress notes do not outline that such an event is to take place. Therefore, based on the review of the progress notes presented, the medical device is not medical necessity.

**Lumbar exercise kit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG), Active Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** The MTUS guidelines do support a home exercise protocol when treating low back pain. However, simple home based exercises can be completed to accomplish the goal. There is no clinical indication for a home exercise kit of multiple devices when simple home based exercises will suffice. Therefore, based on the limited clinical rationale presented, this is not medically necessary.

**Interferential unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guideline (ODG), Interferential Stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**Decision rationale:** The MTUS guidelines support this type of therapy as an isolated intervention. There is no notation that any attempt of a trial of this intervention was completed to demonstrate its efficacy. Therefore, when noting the date of injury, the injury sustained, the treatment rendered to date and the lack of any improvement, there is no clinical indication to support such an intervention. This request is not medically necessary.

**Psychological evaluation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-102.

**Decision rationale:** While noting that the MTUS guidelines support psychological evaluations, there is nothing in the progress notes to indicate what the intended goal is or what issues are being addressed. Therefore, based on this and complete clinical information (specifically what procedure is being pursued), there is insufficient data presented to establish the medical necessity for this evaluation and is therefore considered not medically necessary.

**Clearance with internal medicine specialist:** 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 Other Medical Treatment Guideline or Medical Evidence, Preoperative Evaluation.

**Decision rationale:** Based on the limited clinical information presented, and noting that the exact procedure being pursued is not clear, there is no data presented to suggest comorbidities that require internal medicine evaluation prior to surgical intervention. Therefore, based on the limited data presented, this is not medically necessary.

**Lumbar epidural steroid injection, L4-5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guideline (ODG), Epidural Steroid Injection.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**Decision rationale:** The MTUS allows for epidural steroid injections when radiculopathy is documented and corroborated by imaging or electrodiagnostic studies in individuals who have not improved with conservative care. However, there is objectification of a verifiable radiculopathy either on electrodiagnostic testing or on physical examination. Therefore, the request for this injection is not medically necessary.