

Case Number:	CM13-0022399		
Date Assigned:	10/11/2013	Date of Injury:	07/03/2013
Decision Date:	04/16/2014	UR Denial Date:	08/21/2013
Priority:	Standard	Application Received:	09/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 physician 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 51-year-old female who reported an injury on 07/03/2013. The mechanism of injury involved a fall. The patient is diagnosed with closed fracture of L1 vertebral body, cervical disc herniation with myelopathy, lumbar disc displacement with myelopathy, lesion of the sciatic nerve, and thoracic disc displacement without myelopathy. The patient was seen by [REDACTED] on 07/24/2013. The patient reported persistent pain over multiple areas of the body. Physical examination revealed 3+ spasm and tenderness in bilateral paraspinal muscles from C2-7, painful range of motion of the cervical spine, positive axial compression testing, positive shoulder depression testing, 3+ spasm and tenderness in bilateral paraspinal muscles from T1-9, a 4+ spasm and tenderness to bilateral lumbar paraspinal muscles from L1-S1, painful range of motion of the lumbar spine, positive Kemp's testing, positive straight leg raising, and positive Yeoman's and Braggard's testing. Treatment recommendations included physical therapy, electrical muscle stimulation, chiropractic treatment, a multi-interferential stimulator, and a lumbosacral orthosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBOSACRAL ORTHOSIS FOR PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG);Low Back (updated 05/10/13), Lumbar Supports.

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

Decision rationale: The MTUS/ACOEM Guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As per the documentation submitted, the patient does not demonstrate significant instability upon physical examination. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request is non-certified.

MULTI-INTERFERENTIAL STIMULATOR FOR PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG);Pain (updated 06/07/13), Interferential current stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS), Page(s): 118-120.

Decision rationale: The Chronic Pain Guidelines indicate that interferential current stimulation is not recommended as an isolated intervention. There should be documentation that pain is ineffectively controlled, due to the diminished effectiveness of medications or side effects, a history of substance abuse, or significant pain from postoperative conditions. The patient does not appear to meet criteria for the requested durable medical equipment. Additionally, there is no evidence of a failure to respond to conservative treatment. There is also no documentation of a successful one (1) month trial period, with the unit prior to the request for a purchase. There was no documentation of a treatment plan with the specific short and long term goals of treatment with the unit. Based on the clinical information received, the request is non-certified.