

Case Number:	CM13-0023764		
Date Assigned:	11/15/2013	Date of Injury:	09/15/2010
Decision Date:	01/24/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	09/12/2013

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 Physical Medicine and Rehabilitation and Pain Management, has a subspecialty in Interventional Spine 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 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 28-year-old, male with a date of injury on 9/15/2010 where the patient reported low back pain from walking and felt a pop in his back. He has been diagnosed with lumbosacral sprain/strain with right greater than left radiating leg pain. The orthopedic (AME) Agreed Medical Evaluator felt he was at Maximum Medical Improvement on 9/30/13. The 4/16/13 (EMG/NCV) electromyogram and nerve conduction studies of the lumbar spine and bilateral extremities lower extremity was read as no lumbosacral radiculopathy, no neuropathy or myopathy, yet on 5/15/13 report the patient still complained of 10/10 pain. On 6/25/13, he underwent bilateral L3/4, L4/5 and L5/S1 (TFESI) transforaminal epidural steroid injection. The 9/30/13 AME, [REDACTED] states the patient had 2-sets of ESI's, but was not any better. The (IMR) Independent Medical Reviewer application shows a dispute with the 9/5/13 UR decision, which is by Coventry and denies: full leg wrap purchase E0667; Universal therapy wrap E0249; Kronos Pneumatic Back Brace purchase; Dynamic Therapy System (cold/compression) rental. The UR decision was based on the 6/25/13 report from [REDACTED]

IMR ISSUES, DECISIONS AND RATIONALES

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

Full Leg Wrap purchase E0667: 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), Section on Knee for compression garments.

Decision rationale: The HCPCS code E0667 is for "segmental pneumatic appliance for use with pneumatic compressor, full leg." The 6/25/13 report states the patient was provided bilateral TFESI at L3/4, L4/5, and L5/S1. The patient did not have radiculopathy, neuropathy or myopathy according to the 4/16/13 EMG/NCV. MTUS and ACOEM do not discuss compression wraps for the leg. ODG guidelines recommend these for "management of telangiectases after sclerotherapy, varicose veins in pregnancy, the prevention of edema and deep vein thrombosis (DVT)." There is no evidence that the patient has any of these conditions. The use of the full leg wrap is not in accordance with ODG guidelines.

Universal Therapy Wrap E0249: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 229.

Decision rationale: The HCPCS code E0249 is for a "pad for water circulating heat unit, for replacement only." The description was for a universal therapy wrap, but there was no description or rationale for this wrap, or why it needs replacing. There was no discussion or rationale of how it would be used and for what body region. Without a description for the intended use, it cannot be adequately compared to an evidence-based guideline, and I cannot speculate that it would be used in accordance with a guideline. The physician has not reported the appropriate information necessary to determine whether the item is in accordance with any guidelines, and has not shown the treatment to be in accordance with any evidence-based guideline.

Kronos Pneumatac Back Brace purchase L0631: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301, 308.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines/ACOEM Practice Guidelines states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptoms relief." The patient's complaints started on 9/15/2010, and he still complained of 10/10 pain on the May and June 2013 reports. It is 3-years after the non-specific onset and the patient is already considered to have reached MMI. This is not the acute phase and

ACOEM does not appear to recommend lumbar supports after the acute phase. The request is not in accordance with MTUS/ACOEM guidelines.

Dynamic Therapy System (cold/compression) rental E1399: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines, states: "Surgery" means a procedure listed in the surgery chapter of the Official Medical Fee Schedule with follow-up days of 90 days. The patient is reported to have had a lumbar epidural injection which does not require the 90-day follow-up and does not meet the MTUS definition of Surgery. There is no discussion of a leg surgery or any condition that would required a cold compressive rental. Additionally, there is no description of how the device is to be used or for what body regions it would be applied for treatment. The ODG guidelines for knee/leg states "Recommended as an option after surgery, but not for nonsurgical treatment." The use of the cold/compression therapy is not in accordance with ODG guidelines.