MAXIMUS Federal Services

Case Number:	CM13-0034703		
Date Assigned:	12/11/2013	Date of Injury:	07/06/2011
Decision Date:	01/28/2014	UR Denial Date:	09/23/2013
Priority:	Standard	Application Received:	10/15/2013

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 Internal Medicine and Cardiology, has a subspecialty in Cardiovascular Disease and is licensed to practice in Texas. 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 32-year-old male who reported an injury on 07/06/2011. The patient reportedly sustained an injury to his low back that failed conservative treatments and resulted in surgical decompression. The patient underwent an MRI that revealed the patient was status post discectomy and right laminectomy at the L4-5 level, with a paracentral disc protrusion indenting on the thecal sac. The patient's most recent clinical examination findings included a straight leg raising test on the right, a positive Faber's/Patrick's sign on the right, and a positive Braggard's sign on the right. The patient's lumbar range of motion was reported to be 14 inches from the ground in forward flexion, 15 degrees in extension, 10 degrees in right lateral bending, and full range of motion in left lateral bending; however, pain was reproduced. The patient's diagnosis included status post microdiscectomy at the L4-5. The patient's treatment plan included an MRI, weight management program, and continued H-wave therapy use.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-wave supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave Stimulation Page(s): 117.

Decision rationale: The requested H-wave supplies are not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is being provided H-wave therapy. However, California Medical Treatment Utilization Schedule recommends continued use be based on functional improvement and symptom response. The clinical documentation submitted for review does not provide any quantitative measures or specific objective functional improvements to support the efficacy of this treatment. Therefore, continuation would not be supported. As such, the requested H-wave supplies are not medically necessary or appropriate.

MRI of the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRI.

Decision rationale: The requested MRI lumbar spine is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has right-sided positive straight leg raising test. The American College of Occupational and Environmental Medicine does recommend MRIs to support neurological deficits. However, the ODG do not recommend repeat imaging unless there are progressive neurological deficits or a significant change in the patient's pathology. The clinical documentation submitted for review does not provide any evidence of progressive neurological deficits or a significant change in the patient's pathology. Therefore, an additional MRI would not be supported by guideline recommendations.

A six month gym membership: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Gym Memberships.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Gym Memberships.

Decision rationale: Gym membership for six months is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has continued deficits that would benefit from an exercise program. However, Official Disability Guidelines do not recommend a medical prescription for a gym membership unless the patient has failed to progress while participating in an unsupervised home exercise program. Additionally, it is stated that gym memberships, health clubs, swimming pools, athletic clubs, etc. would not generally be considered medical treatment, and are, therefore, not covered under

these guidelines. The clinical documentation submitted for review does not provide evidence that the patient has failed to progress in a home exercise program and requires the need for exercise equipment that cannot be used in the home. As such, the requested gym membership for six months is not medically necessary or appropriate.