

<b>Case Number:</b>	CM13-0045798		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	09/05/2013
<b>Decision Date:</b>	09/30/2014	<b>UR Denial Date:</b>	09/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2013

### 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 & Rehabilitation 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 43-year-old female who has submitted a claim for lumbar neuritis/radiculitis and lumbosacral strain associated with an industrial injury date of 09/05/2013. Medical records from 09/09/2013 to 09/23/2013 were reviewed and showed that patient complained of low back pain graded 3-8/10 radiating down right lower extremity. Physical examination revealed tenderness to palpation over right paraspinal muscles, decreased right patellar tendon reflex, weakness of right toe extensors and quadriceps, intact sensation, and positive SLR on the right at 60 degrees. Treatment to date has included physical therapy and pain medications. Utilization review dated 09/26/2013 denied the request for DME: Theraband Blue because more elaborate personal care where outcomes were not monitored may not be covered.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable Medical Equipment: Theraband Blue:** Upheld

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

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

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Knee Chapter was used instead. A Durable Medical Equipment (DME) is recommended generally if there is a medical need and if the device meets the Medicare's definition of DME as: can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. In this case, the patient complained of low back pain with radiation down right lower extremity which prompted request for Theraband. However, Theraband does not meet the criteria for DME as it is not customarily used to serve a medical purpose and is useful even in the absence of illness or injury. Therefore, the request for Durable Medical Equipment: Theraband Blue is not medically necessary.