

Case Number:	CM13-0049943		
Date Assigned:	12/27/2013	Date of Injury:	02/21/2008
Decision Date:	03/24/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/08/2013

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 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 47-year-old male with dates of injury on 08/16/2006, 08/17/2006, and 08/17/2007. The injuries occurred in the course of his usual work duties. The patient was seen on 07/31/2013 for a followup visit for a complaint of low back pain that radiates to bilateral lower extremities. It is noted that the patient's pain level was increased with average pain level of 9/10 with medication and 10/10 without medication. The patient reports activities of daily living limitations in the following areas of self-care and hygiene, activity, ambulation, sleep, and sex. The patient reports significant functional improvement and improved mobility, physical therapy was very helpful per the patient. Upon exam, the patient was observed to be in moderate distress, range of motion of the lumbar spine revealed moderate reduction secondary to pain, spinal vertebral tenderness was noted in the lumbar spine at the L4 to S1 level, lumbar myofascial tenderness and paraspinal muscle spasm was noted on palpation. The patient was noted with diagnosis of lumbar radiculopathy, lumbar disc degeneration, lumbar facet arthropathy, lumbar spinal stenosis, chronic pain, insomnia secondary to chronic pain, erectile dysfunction due to chronic pain and opiate medication use. Per the physician, the plan and treatment are request for 4 additional weeks of physical therapy due to the patient showing improved pain control and functional improvement. Lumbar orthosis prescribed, followup in 2 months for re evaluation, medication is being refilled. The patient is on the following medications to include gabapentin 600 mg 1 tablet 3 times daily, hydrocodone 10/325 mg 1 tablet every 8 hours, Senna/docusate 1 tablet twice daily, Lunesta 3 mg 1 tablet at night, Voltaren 75 mg 1 tablet by mouth twice daily, omeprazole 20 mg 1 tablet daily, and Viagra 100 mg use as directed by physician for 10 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decision for DME: Infra-red device: 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): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Infrared Therapy

Decision rationale: The request is non-certified. The patient is a 47-year-old male, again with dates of injury of 08/16/2006, 08/17/2006, and 08/17/2007, in the course of his usual work duties. The patient again seen for lower back pain that radiates to the bilateral lower extremities. The 07/31/2013 note did note the patient reports significant functional improvement and improved mobility with physical therapy. On exam, the patient did have some range of motion limitations of the lumbar spine secondary to pain, vertebral tenderness noted to the L4 to S1 level, lumbar myofascial tenderness, and paraspinous muscle spasms were noted on palpation. The CA MTUS/ACOEM Guidelines note at home local applications of heat or cold are as effective as those performed by a therapist. The ODG guidelines note for infrared therapy, not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of infrared therapy for treatment of acute low back pain, but only if used in adjunct to a program of evidence-based conservative care/exercise. The Guidelines do not recommend this infrared therapy and the documentation failed to indicate this requested treatment was to be provided as an adjunct to an exercise program. As such, the request for DME: Infra-red device is non-certified.