

Case Number:	CM14-0103696		
Date Assigned:	07/30/2014	Date of Injury:	07/09/2012
Decision Date:	10/14/2014	UR Denial Date:	06/18/2014
Priority:	Standard	Application Received:	07/07/2014

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 Family Medicine 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 66-year-old female who has submitted a claim for lumbar strain associated with an industrial injury date of 07/09/2012. Medical records from 06/2013 to 11/15/2013 were reviewed and showed that patient complained of chronic low back pain graded 7/10 radiating down the left leg. Physical examination (11/11/2013) revealed decreased lumbar ROM, hypesthesia along left L5 dermatomal distribution, weakness of bilateral extensor hallucis longus, decreased bilateral patellar and Achilles tendon reflexes, and positive bilateral SLR test. MRI of the lumbar spine dated 07/15/2013 revealed L5-S1 disc bulge with mild to moderate right and moderate left neural foraminal narrowing. Treatment to date has included physical therapy, Norco, Diclofenac, and Amitriptyline. Utilization review dated 06/18/2014 denied the request for retrospective lumbar sacral orthosis because the guidelines do not support back brace for treatment of chronic musculoskeletal pain. Utilization review dated 06/18/2014 denied the request for retrospective motorized CTU because there was lack of evidence-based efficacy of cold therapy unit. Utilization review dated 06/18/2014 denied the request for lumbar home exercise kit because there was no evidence-based efficacy or guidelines support. Utilization review dated 06/18/2014 denied the request for Thermophore heating pad purchased 01/30/2014 because there was evidence-based proven efficacy following lumbar epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Lumbar Sacral Orthosis Brace (DOS 1/30/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports

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

Decision rationale: The California MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines (ODG) was used instead. Official Disability Guidelines states that lumbar support is not recommended for prevention of back pain. A systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. In this case, the patient complained of chronic low back pain. However, the medical records submitted for review were from 06/2013 to 11/15/2013. Medical necessity for the request cannot be established due to insufficient information. The current clinical and functional status of the patient is unknown. Therefore, the request for retrospective lumbar sacral orthosis brace (DOS 1/30/14) is not medically necessary.

Retrospective Motorized CTU (cold therapy unit) (DOS 1/30/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter: Cold/heat packs

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

Decision rationale: The California MTUS does not specifically address continuous-flow cryotherapy; however, the Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for non-surgical treatment. Postoperative use generally may be up to 7 days, including home use. In this case, the patient complained of chronic low back pain. However, the medical records submitted for review were from 06/2013 to 11/15/2013. Medical necessity for the request cannot be established due to insufficient information. The current clinical and functional status of the patient is unknown. Therefore, the request for retrospective motorized CTU (cold therapy unit) (DOS 1/30/14) is not medically necessary.

Retrospective Lumbar Home Exercise kit (DOS 1/30/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Exercise Kit-Durable medical equipment (DME)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Home exercise kits; Knee & Leg Chapter, Exercise equipment and durable medical equipment

Decision rationale: The California MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines was used instead. Official Disability Guidelines Shoulder Chapter recommends home exercise kits where home exercise programs and active self-directed home physical therapy are recommended. The Official Disability Guidelines Knee and Leg Chapter states that exercise equipment are considered not primarily medical in nature. It also states that durable medical equipment should be primarily and customarily used to serve a medical purpose. In this case, the patient complained of chronic low back pain. However, the medical records submitted for review were from 06/2013 to 11/15/2013. Medical necessity for the request cannot be established due to insufficient information. The current clinical and functional status of the patient is unknown. Therefore, the request for retrospective lumbar home exercise kit (DOS 1/30/14) is not medically necessary.

Retrospective Thermophore heating pad (DOS 1/30/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/heat packs

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

Decision rationale: The California MTUS does not address this topic specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Low Back chapter, Cold/heat packs was used instead. The Official Disability Guidelines state that cold/heat packs are recommended as an option for acute pain. At home, local applications of cold packs in the first few days of acute complaint; thereafter, applications of heat packs or cold packs are recommended. In this case, the patient complained of chronic low back pain. However, the medical records submitted for review were from 06/2013 to 11/15/2013. Medical necessity for the request cannot be established due to insufficient information. The current clinical and functional status of the patient is unknown. Therefore, the request for retrospective Thermophore heating pad (DOS 1/30/14) is not medically necessary.