

Case Number:	CM14-0106538		
Date Assigned:	09/05/2014	Date of Injury:	08/13/2013
Decision Date:	10/16/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	07/09/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 55 year-old male was reportedly injured on 8/13/2013. The mechanism of injury is noted as a pushing injury. The most recent progress note, dated 5/22/2014, indicates that there are ongoing complaints of low back pain that radiates into the right lower extremity. The physical examination demonstrated lumbar spine: positive straight leg raise test on the right, Braggard's testing is positive on the right, a Kemp's test is positive bilaterally and Yeoman signs were positive bilaterally. The patient also had a decreased range of motion of the lumbar spine with pain at extremes, reflexes within normal limits on the left and decreased on the right, difficulty with heel-toe walk, muscle strength of 5/5 in bilateral lower extremities and decreased sensation over the L4 dermatome on the right side. No recent diagnostic studies are available for review. Previous treatment includes medications, physical therapy, and conservative treatment. A request had been made for lumbar brace, ProTech multi Stim unit, Solar care heating system, and was not certified in the pre-authorization process on 6/13/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar brace.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines

-Treatment in Workers' Compensation (ODG-TWC) Low Back Procedure Summary last updated 05/12/2014.

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

Decision rationale: The MTUS/ACOEM practice guidelines do not support the use of a lumbar-sacral orthosis or other lumbar support devices for the treatment or prevention of low back pain except in cases of specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The claimant is currently not in an acute postoperative setting and there is no documentation of instability or spondylolisthesis with flexion or extension plain radiographs of the lumbar spine. As such, this request is not considered medically necessary.

Pro Tech Multi Stim Unit (rental or purchase): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: The MTUS treatment guidelines recommend against using a transcutaneous electrical nerve stimulation (TENS) unit as a primary treatment modality and indicate that a one-month trial must be documented prior to purchase of the unit. Based on the clinical documentation provided, physical therapy and a TENS unit is helping significantly; however, there is no documentation of a full one-month trial. The MTUS requires that an appropriate one-month trial should include documentation of how often the unit was used, the outcomes in terms of pain relief/reduction and improvement in function. Review of the available medical records, fails to document a required one-month TENS trial. As such, this request is not considered medically necessary.

Solarcare Fir heating system (rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation (ODG-TWC) Low Back Procedure Summary last updated 05/12/2014.

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 & Thoracic (Acute & Chronic), Heat Therapy

Decision rationale: The ODG guidelines state heat therapy can be effective for treating low back pain. After review of the medical documentation provided it is noted the injured worker does have chronic low back pain; however, there is insufficient evidence-based medical trials to support the use of this device. Manual applications of hot packs are cost-effective and just as efficacious. Therefore, this request is deemed not medically necessary.

