

Case Number:	CM14-0157708		
Date Assigned:	10/01/2014	Date of Injury:	09/30/2010
Decision Date:	10/29/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/25/2014

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 Occupational 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:

Patient is a 63 year-old male with date of injury 09/30/2010. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 08/06/2014, lists subjective complaints as pain in the low back with radicular symptoms down both legs and groin area. Patient is status post right lumbar differential diagnostic facet block at L4-5 and L5-S1 and middle branches of L3 and L4 and dorsum ramus of L5 on the right side dated 06/17/2013. Examination of the lumbar spine revealed 4+ spasm and tenderness to the bilateral lumbar paraspinal muscles from L4 to S1 and quadratus lumborum. Range of motion was decreased. Kemp's test was positive on the left. Straight leg raising test was positive bilaterally. Braggard's was positive bilaterally. The L5 and S1 dermatomes were decreased on the right to light touch. Diagnosis: 1. Cervical disc herniation with myelopathy 2. Lumbar disc displacement with myelopathy 3. Lateral epicondylitis of the bilateral elbows 4. Thoracic spondylosis without myelopathy 5. Myofascitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar exercise kit, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014

Decision rationale: The MTUS and the Official Disability Guidelines are silent on this issue. According to the Blue Cross Clinical UM Guideline, health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor are not medically necessary. A lumbar exercise kit is considered workout equipment and is not medically necessary.

Purchase of Motorized cold therapy unit with pad for lumbar spine: 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), Treatment Index, 11th Edition (web), 2013, Knee

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), Cold/heat packs

Decision rationale: According to the Official Disability Guidelines, there is minimal evidence supporting the use of cold therapy except in the acute phase of an injury or for the first seven days postoperatively. The patient's injury is 4 years old. The ODG do not support the use of cryotherapy for degenerative lumbar disc disease or myofascitis. Therefore, the request for Purchase of Motorized cold therapy unit with pad for lumbar spine is not medically necessary and appropriate.