

Case Number:	CM14-0033790		
Date Assigned:	06/20/2014	Date of Injury:	08/07/2007
Decision Date:	07/22/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	03/17/2014

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 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 injured worker is a 57 year old female who reported an injury on 06/16/2007 due to a lifting injury. The clinical note dated 04/09/2014 noted the injured worker presented with severe neck and low back pain. Upon exam of the cervical spine, C4 had a bilateral decrease in sensation, pain upon palpation to the bilateral shoulder joints, and moderate tenderness in the cervical region. The low back exam demonstrated severe tenderness in the low back region, increasing pain upon extension, groaning with motion, positive bilateral straight leg raise, and had extreme difficulty rising from a seated to standing position. There was decreased sensation in the lower extremity bilateral L3-L5 distribution and the right S1 nerve distribution. Prior therapy included medication, surgery, and injections. The diagnoses were cervical spondylosis, bilateral shoulder pain, L4-L5 grade 2 spondylolisthesis, and L5-S1 right-sided disc herniation with radiculopathy. The provider recommended retrospective request for IF unit, a retrospective back brace, retrospective water circulating cold unit, and a retrospective heat/moist pad. The provider's rationale was not provided. A Request for Authorization Form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (4/18/13) request for IF unit and supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

Decision rationale: The retrospective request for IF unit and supplies is not medically necessary. The California MTUS Guidelines do not recommend an IF unit as an isolated intervention. There is no quality evidence of effectiveness, except in conjunction with recommended treatments including return to work, exercise, and medications, and limited evidence of improvement on those recommended treatments alone. It may possibly be appropriate for the following conditions if documented, the pain is ineffectively controlled due to diminished effectiveness of medication, pain is ineffectively controlled with medication due to side effects, there is a history of substance abuse, significant pain from postoperative conditions with limited ability to perform exercise programs/physical therapy treatment, or unresponsiveness to conservative measures. There is a lack of evidence in the documentation provided that would reflect diminished effectiveness of medications, a history of substance abuse, or any postoperative conditions which would limit the injured worker's ability to perform exercise programs/physical therapy treatment. The included medical documentation did not have evidence of unresponsiveness to conservative measures. The requesting physician did not include an adequate and complete assessment of the injured worker's objective functional condition which would demonstrate deficits needing to be addressed as well as establish a baseline by which to assess objective functional improvement over the course of therapy. As such, the request is not medically necessary.

Retrospective 4/18/13 LSO back brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The request for retrospective LSO back brace is not medically necessary. The California MTUS/ACOEM Guidelines state, because evidence is insufficient to support using vertebral axial compression for treating low back injuries, it is not recommended. There is no medical indication that a back brace would assist in the treatment for the injured worker. As such, the request is not medically necessary.

Retrospective 4/18/13 of Water Circulating Cold Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The request for retrospective 04/18/2013 of water circulating cold unit is not medically necessary. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery for up to 7 days, including home use. The request for 1 cold unit exceeds the recommendation of the guidelines. The provider's request did not indicate whether the request was for the purchase of or rental of the unit, and the medical documents provided do not indicate a medical need for the circulating cold unit that would fall within the guideline limitations. As such, the request is not medically necessary.

Retrospective 4/18/13 of a Heat/Moist Pad: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Heat Therapy.

Decision rationale: The request for retrospective 04/18/2013 of a heat/moist pad is not medically necessary. The Official Disability Guidelines state that there is moderate evidence that heat therapy provides a small, short-term reduction in pain and disability in acute and subacute low back pain, and that the addition of exercise further reduces pain and improves function. The provider's request for heat/moist pad did not specify the type of heat/moist pad in reference to treatment for the injured worker. The site that the heat/moist pad was intended for was not provided. As such, the request is not medically necessary.