

Case Number:	CM14-0035711		
Date Assigned:	06/23/2014	Date of Injury:	02/29/2012
Decision Date:	07/28/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	03/20/2014

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 & 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 46-year-old male who reported an injury on 02/29/2012 secondary to unspecified mechanism of injury. The injured worker was evaluated on 02/12/2014 for a followup after an MRI (magnetic resonance imaging). The exam noted a positive straight leg raise on the right side with notable weakness to the right tibialis anterior and gastroc soleus. The diagnoses included low back pain with radiculopathy, disc herniation on the right side at L4-5, right-sided elbow sprain/strain, cervical and intrascapular sprain, sleep disturbance, sexual dysfunction, and aggravation of diabetes. The exam noted a positive straight leg raise and right sided weakness. The treatment plan included an L4-5 laminectomy and discectomy. The request for authorization and rationale for request were not found in the documentation provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

DURABLE MEDICAL EQUIPMENT MI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, Continuous-flow cryotherapy, and Low Back, Codl/heat pack.

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

Decision rationale: The request for an iceless cold therapy unit with DVT and lumbar wrap is non-certified. The Official Disability Guidelines (ODG) may recommend durable medical equipment if there is a medical need and if the evidence or system meets [REDACTED] definition of durable medical equipment. The request does not include the rationale, duration and frequency for usage of the requested durable medical equipment. Therefore, a review cannot be completed on the medical necessity of the requested equipment. Therefore, due to the lack of information related to the usage to support the medical necessity of the requested medical equipment, the request is non-certified.