

Case Number:	CM14-0038970		
Date Assigned:	06/27/2014	Date of Injury:	04/02/2013
Decision Date:	07/28/2014	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	04/02/2014

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 Preventive Medicine and is licensed to practice in Indiana. 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 49 year old employee sustained a work-related back injury in April 2013, and has been diagnosed with lumbago and lumbar spine radiculitis. She has had continuous low back pain radiating to the right leg with decreased range of motion of the lumbar spine. She has had PT and is currently taking pain medications including Norco, Tramadol, Flubiprofen, Dicofenac, Capsaicin, and Flector patch.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi stim unit for 5 months: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-117, 120-121.

Decision rationale: For stimulator devices, the MTUS referenced above states that they should not be used as a primary treatment modality, but a one-month trial can be used. However, in the medical records of this injured worker there is no justification for a multi-stim in conjunction with a full pain treatment plan. There is no mention of intractable pain or the failure of other treatment modalities. Therefore, a multi-stim device is not medically necessary.

Heat/cold unit purchase E0217: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines, low back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

Decision rationale: The E0217 is a water circulating heat pad with a pump. This specific device is not referenced in the guidelines referenced above. However, there is a table comparing the evidence and recommendations of various treatment modalities for low back pain. Within the guidelines, at home applications of local heat or cold are given a D rating, and are not recommended for use. Therefore, an E0217 unit is not medically necessary.