

Case Number:	CM14-0067066		
Date Assigned:	07/11/2014	Date of Injury:	07/17/2012
Decision Date:	08/29/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/12/2014

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, has a subspecialty in Interventional Spine 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:

Pain/stiffness with cold weather, and continued radiating lower lumbar rated 7/10 per 3/6/14 report. Patient had a recent fall which injured neck, right middle finger, and flared up lumbar pain on 2/27/14. Based on the 3/6/14 progress report provided by [REDACTED] the diagnosis is probably lumbar facet syndrome. Exam on 3/6/14 showed tenderness to palpation over lower lumbar spine midline. Bilateral SI joint. Paraspinal musculature with guarding. L-spine range of motion is 80%. Tenderness over bilateral musculature trapezius. Shoulder depression. Cervical range of motion is 90%. Primary treatment provider is requesting lumbosacral orthosis (LSO) brace for purchase, interferential stimulator (IF Unit) for purchase and one year supplies, and hot and cold pack with wrap. The utilization review determination being challenged is dated 4/29/14 and denies hot and cold pack with wrap as there is no explanation why it would be of more benefit compared to at-home application of hot/cold packs. The requesting provider provided treatment reports from 11/27/2013 to 3/6/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbosacral Orthosis (LSO) brace for purchase.: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation ODG guidelines for lumbar supports has the following: Not recommended for prevention. Recommended as an option for treatment. See below for indications.

Decision rationale: This patient presents with neck pain and lower back pain. The treater has asked for lumbosacral orthosis (LSO) brace for purchase on 3/6/14. Regarding lumbar supports: ODG guidelines do not recommend for prevention but allow as an option for treatment for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). In this case, the patient does not present with any of the diagnoses that ODG allows for the indication of a lumbar support. The requested lumbosacral orthosis (LSO) brace for purchase is not considered medically necessary at this time. Request for Lumbosacral orthosis brace is not viewed as medically necessary and appropriate.

Interferential stimulator (IF Unit) and supplies for purchase and one year supplies.:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS) Page(s): 118-120.

Decision rationale: This patient presents with neck pain and lower back pain. The treater has asked for interferential stimulator (IF Unit) for purchase and one year supplies on 3/6/14. Per MTUS guidelines, interferential units are recommended if medications do not work, history of substance abuse or for post-operative pain control. After a one-month trial there should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A jacket should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. In this case, the treater has asked for a purchase of an interferential stimulator but there is no evidence of a previous one-month trial. MTUS recommends a trial prior to purchase of an IF unit. Request for interferential stimulator IF unit and supplies for purchase is not considered medically necessary and appropriate.

Hot and Cold Pack with Wrap: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back-Heat Therapy, Cold/heat packs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Foot/Ankle ODG guidelines has the following regarding continuous-flow cryotherapy.

Decision rationale: This patient presents with neck pain and lower back pain. The medical provider has asked for hot and cold pack with wrap on 3/6/14. ODG lumbar chapter recommends hot/cold therapy as an option for acute pain. It recommends at-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Considering patient had a recent fall that exacerbated lower back pain, a hot/cold wrap appears reasonable for this patient's condition. Hot and cold pack with wrap is medically necessary and appropriate.