

Case Number:	CM14-0069530		
Date Assigned:	07/14/2014	Date of Injury:	04/01/2014
Decision Date:	09/19/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/14/2014

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:

The patient is a 21 year old female who sustained an injury to the lumbar spine on 04/01/2014. According to the UR, the patient was noted to have moderate to severe pain and rated it as 5/10. She does have associated numbness and tingling of lower extremities as well. Her exam revealed tenderness of the thoracolumbar spine and paravertebral muscle. Range of motion of the back is restricted and revealed extension to 20/30; lateral flexion to the left 20/45; lateral flexion to the right is 30/45; lateral rotation to 30/30 bilaterally. Straight leg raise is positive. She is diagnosed with lumbar sprain/strain and back prescribed. She received a Kenalog and ketorolac injections and Medrol Dose-pak. A motorized cold therapy, back brace support, FCE (functional capacity evaluation) and 6 sessions of chiropractic therapy have been requested. There are no other medical records available for review. Prior utilization review dated 04/30/2014 states the request for motorized cold therapy is denied as guideline criteria has not been met; interferential unit, functional capacity evaluation is denied as it is not medically necessary; back brace support 63 inches is denied as it is not indicated to be medically necessary; chiropractic x 6 is denied as it is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized Cold therapy: 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), Low Back, Cold/Heat Packs, Continuous Flow Cryotherapy Other Medical Treatment Guideline or Medical Evidence: <http://medsourcellc.com/resources/Hot-Cold-Therapy.html>.

Decision rationale: According to ODG guidelines, cold therapy is recommended for acute low back pain but evidence is more favorable for heat therapy. Continuous-flow cryotherapy is only recommended post-operatively. However, the patient did not have surgery. Therefore, this request is not medically necessary.

Interferential Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Interferential Current Stimulation.

Decision rationale: According to MTUS guidelines, interferential current stimulation may be indicated if the patient is unresponsive to conservative measures or if pain is ineffectively controlled from medications. However, in this case there is no documentation of failure of standard conservative measures. No rationale is provided for the request. Therefore, this request is not medically necessary.

Functional Capacity Evaluation: 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: Decision based on MTUS Chronic Pain Treatment Guidelines WORK CONDITIONING, WORK HARDENING Page(s): 125-127. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 - Independent Medical Examinations and Consultations, page 511 Official Disability Guidelines (ODG), Fitness for Duty, Functional capacity evaluation.

Decision rationale: According to MTUS guidelines, functional capacity evaluation (FCE's) may be indicated prior to entrance into a work hardening program. Routine use of FCE's is not recommended as the ability of FCE's to predict return to work is questionable. In this case, the patient is one month out from injury. The patient is not entering a Work Hardening Program. Work restrictions are easily determined for acute uncomplicated low back pain from history and examination. The patient is not at or near MMI. Therefore, this request is not medically necessary.

Back Brace Support 63 inches: 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: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar Support.

Decision rationale: According to MTUS guidelines, lumbar supports are not recommended beyond the acute phase. According to ODG guidelines lumbar supports are not indicated for prevention. There is low-quality evidence for the treatment of non-specific low back pain. In this case, the patient is one month out from low back injury. No rationale is provided for use of a lumbar support. Therefore, this request is not medically necessary.

Chiropractic x 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: According to MTUS guidelines, chiropractic manipulation is recommended for acute musculoskeletal pain of the spine. The 6 sessions are recommended initially with further sessions dependent upon treatment response. In this case, the patient apparently has already been approved for 6 chiropractic sessions, but response is not documented. Therefore, this request is not medically necessary.