

Case Number:	CM14-0079140		
Date Assigned:	07/18/2014	Date of Injury:	07/01/1999
Decision Date:	10/16/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/29/2014

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, 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:

The patient is a 50-year-old male with date of injury of 07/01/1999. The listed diagnoses per [REDACTED] from 04/15/2014 are prior history of work injury with lumbar disk protrusions at L4-L5 and L5-S1 levels, long history of intermittent sciatica with radiation to both lower extremities, previously worse on the left side, but recently, it is worse sciatica on the right side with weakness and lumbar disk protrusion at L4-L5 and L5-S1 levels. According to this report, the patient complains of intermittent pain in the low back with radiating pain to his bilateral lower extremities, right greater than left. The patient reports cramping, numbness, and tingling in his bilateral lower extremities. He rates his pain 3/10 to 4/10. Patient reports difficulty sleeping and awakens with pain and discomfort. He also complains of intermittent pain in the buttocks, legs, knees, and feet radiating from his lower back. The examination shows the patient ambulates with a slow, steady, balanced gait. There is flattening of the lumbar lordosis with no scars, ecchymosis, or swelling noted. Tenderness and spasms are noted from L3 to the sacrum, central and paralumbar location. There is a positive sciatic notch tenderness noted bilaterally. Straight leg raise is positive on the right. Pulses are 2+ and symmetrical in the lower extremities. The utilization review denied the request on 05/06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-force stimulator purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 114-117.

Decision rationale: This patient presents with low back pain. The provider is requesting X-Force Stimulator purchase. The MTUS Guidelines pages 114 to 116 on TENS unit states that it is not recommended as a primary treatment modality, but a 1-month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. The records do not show that the patient has tried TENS unit in the past. In this case, MTUS Guidelines recommend a 1-month home-based TENS trial to determine its efficacy in terms of pain relief and function. Therefore the request is not medically necessary.

Kronos lumbar pneumatic brace: Upheld

Claims Administrator 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 Procedure Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301 & 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: This patient presents with low back pain. The provider is requesting Kronos lumbar pneumatic brace. The ACOEM Guidelines page 301 on lumbar bracing states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines regarding lumbar supports states, "Not recommended for prevention; however, recommended as an option for compression fracture and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain, very low quality evidence, but may be a conservative option." The 04/15/2014 report notes, "I prescribed the Kronos lumbar pneumatic brace to empower my patient to become independent and to help them take a role in the management of their symptoms. The Kronos lumbar pneumatic brace is medically necessary as it can help cure and/or relieve the patient's injury." In this case, ODG and ACOEM Guidelines do not support the use of lumbar supports for the treatment or prevention of low back pain. Therefore the request is not medically necessary.

SolarCare FIR heating system: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Low Back Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Infrared Therapy

Decision rationale: This patient presents with low back pain. The provider is requesting Solar Care FIR Heating System. The MTUS and ACOEM Guidelines do not address this request. However, ODG Guidelines on infrared therapy states that it is not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute lower back pain, but only if used as an adjunct to a program of evidence-based conservative care (exercise). The 04/15/2014 report notes, "The Solar Care FIR Heating System is medically necessary as it can help cure and/or relieve the patient's injury." In this case, the provider does not explain why infrared heating system is preferred over conventional heat therapy. ODG does not support it unless it is tried on a short-term as an adjunct to other programs. Therefore the request is not medically necessary.