

Case Number:	CM14-0084524		
Date Assigned:	07/21/2014	Date of Injury:	10/04/2013
Decision Date:	09/25/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	06/06/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 52 year old male whose date of injury is 10/04/2013. The injured worker sustained an injury to his low back secondary to a fall. Treatment to date includes chiropractic treatment, physical therapy, medication management and activity modification. Lumbar magnetic resonance image dated 03/14/14 revealed L4-5 disc desiccation and degeneration. There is a 3-4 mm disc protrusion which extends into both neural foraminal exit zones. At L5-S1 there is a 2-3 mm disc protrusion which extends into the left neural foraminal exit zone. Progress report dated 07/15/14 indicates that medications include Ambien, Simethicone, Prilosec, Fioricet, Norco and Cialis. Physical therapy provided some temporary benefit. Diagnoses are postconcussive syndrome, cervical spine herniated nucleus pulposus, lumbar spine myoligamentous injury, secondary sleep deprivation, secondary stress and anxiety and hypertension.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME - Optimum Spine Kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Electrical Stimulators. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-Treatment in Workmans Compensation (TWC): Low back - Lumbar & Thoracic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise
Page(s): 46-47.

Decision rationale: Based on the clinical information provided, the request for durable medical equipment Optimum spine kit is not recommended as medically necessary. There is insufficient clinical information provided to support this request. The specific contents of the request are not documented, and therefore it is unclear what exactly the request consists of at this time. Therefore, medical necessity cannot be established in accordance with California Medical Treatment Utilization Schedule guidelines.