

Case Number:	CM14-0160764		
Date Assigned:	10/03/2014	Date of Injury:	07/15/2014
Decision Date:	04/07/2015	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	09/29/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 48-year-old female who reported an injury on 07/15/2014. The mechanism of injury was due to continuous and repetitive motion. Her diagnoses include cervical spine sprain/strain to rule out herniated nucleus pulposus, thoracic spine sprain/strain, lumbar spine sprain/strain to rule out herniated nucleus pulposus, bilateral upper and lower extremity radicular pain and paresthesias, bilateral wrist sprain/strain rule out carpal tunnel syndrome, bilateral de Quervain's tenosynovitis, hypertension, and bilateral hearing loss. Her past treatments included physical therapy, injections, braces, hot packs, massage, electrical stimulation, and medication. On 08/26/2014, the injured worker complained of occasional headaches, dizziness, blurred vision, and fatigue. The injured worker also complained of hearing loss of both ears. The physical examination of the lumbar spine revealed continuous pain in the lower back radiating to the bilateral lower extremities, right greater than left, with pain present 100% of the time. Her pain scale is rated 7/10 to 8/10. The injured worker also had moderate tenderness to palpation over the lumbar paravertebral musculature. The lumbar spine range of motion was noted with forward flexion of 45 degrees, extension of 5 degrees, right lateral bending to 10 degrees, and left lateral bending to 10 degrees. The injured worker also had a positive straight leg raise on the left, Bragard's test on the left, bowstrings test on the left, and positive Valsalva maneuvers bilaterally. The injured worker was also indicated to have deficits upon neurological examination. Her relevant medications included omeprazole 40 mg, atenolol 50 mg, lorazepam 1 mg, prednisone 10 mg, tramadol 325 mg, and Aleve. The treatment plan included DME: XForce interferential stimulator unit, DME: solar care FIR heating system, and

DME: Kronos lumbar pneumatic brace. The precise rationale was not provided. A Request for Authorization form was submitted on 08/26/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: XForce interferential stimulator unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120-122.

Decision rationale: The request for DME: XForce interferential stimulator unit is not medically necessary. According to the California MTUS Guidelines, interferential current stimulation units are not recommended as an isolated intervention; however, they may be allotted for a trial if used in conjunction with approved conservative treatments. The criteria for an interferential unit include documentation that pain is ineffectively controlled due to diminished effectiveness of medications, medication side effects, history of substance abuse, significant pain from postoperative conditions limiting ability to perform in conservative treatments, and an unresponsiveness to conservative measures. The injured worker was indicated to have complaints of headaches, dizziness, blurred vision, and fatigue. However, there was lack of documentation in regards to pain that was ineffectively controlled by medications, medication side effects, or had a history of substance abuse. There was also lack of documentation to indicate that injured worker had significant postoperative pain limiting ability to perform in conservative therapies, or was unresponsive to conservative measures. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

DME: Solar care FIR heating system: Upheld

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.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines low back, Infrared therapy (IR).

Decision rationale: The request for DME: Solar care FIR heating system is not medically necessary. According to Official Disability Guidelines, infrared therapy units are not recommended over other heat therapies. The guidelines do indicate a limited trial of infrared therapy for acute low back pain if used as an adjunct to evidence based conservative care. The injured worker was indicated to have complaints of dizziness, headaches, blurred vision, and fatigue. However, there was a lack of documentation in regards to acute back pain to warrant a

limited trial. There was also lack of documentation the unit would be used in adjunct to a program of evidence based conservative therapy. Furthermore, the guidelines do not recommend the use of infrared therapies over other heat therapies as at home local applications of heat are as effective as those performed by a therapist. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

DME: Kronos lumbar pneumatic brace: Upheld

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

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, Orthotrac vest.

Decision rationale: The request for DME: Kronos lumbar pneumatic brace is not medically necessary. According to the California MTUS/ACOEM Guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Furthermore, the Official Disability Guidelines state that lumbar supports are not recommended due to lack of evidence to support the use of the device. The injured worker was indicated to have complaints of headaches, dizziness, blurred vision, and fatigue. However, there was a lack of documentation to indicate medical necessity for a lumbar support. Furthermore, the guidelines do not recommend the use lumbar supports over an Orthotrac vest for stabilization and decompression. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.