MAXIMUS Federal Services

Case Number:	CM14-0197190		
Date Assigned:	12/05/2014	Date of Injury:	11/05/2013
Decision Date:	07/31/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/24/2014

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: Texas, California
Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 50-year-old female patient, who sustained an industrial injury on 11/5/13. The diagnoses have included herniated lumbar disc with degenerative joint disease (DJD), spinal stenosis with radiculopathy, herniated cervical disc with radiculopathy and degenerative disc disease (DDD), cephalgia, right knee internal derangement and bilateral wrist tendonitis. Per the physician progress note dated 9/15/14, she had complains of pain in the bilateral knees and lumbar spine with numbness in the left third and fifth toes and swelling in the left ankle. The physical examination revealed lumbar spine range of motion with flexion 45 degrees, extension 15 degrees, and bending 20 degrees bilaterally, positive Lasegue's test bilaterally, positive straight leg raise on the right and cross positive test on the left, decreased sensation at L5 and S1 dermatome level on the right and weakness in the big toe dorsiflexors and big toe plantar flexors bilaterally; bilateral knee- tenderness, positive chondromalacia patellar compression test, range of motion- right/left flexion 115/125 degrees and extension on the right knee -3 degrees. The medications list includes Norco. The diagnostic testing that was performed included x-rays of the lumbar spine and Magnetic Resonance Imaging (MRI) of the lumbar spine, Magnetic Resonance Imaging (MRI) and CT scan of the cervical spine. Treatment to date has included medications, activity modifications, off work, diagnostics, pain management, physical therapy, rest and home exercise program (HEP). The physician requested treatments included LSO Lumbar Brace and Hot/Cold Therapy Unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

LSO Lumbar Brace: 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): 298.

Decision rationale: LSO Lumbar Brace Per the ACOEM guidelines "There is no evidence for the effectiveness of lumbar supports". The cited guidelines do not recommend lumbar support for low back pain. Evidence of a recent lumbar fracture, spondylolisthesis, recent lumbar surgery or instability was not specified in the records provided. In addition, response to previous conservative therapy including physical therapy is not specified in the records provided. The medical necessity of LSO Lumbar Brace is not medically necessary for this patient.

Hot/Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Page 300Physical methods,Chronic Pain Treatment Guidelines Physical therapy Page(s): 98.

Decision rationale: Hot/Cold Therapy Unit Per the ACOEM guidelines, "At-home local applications of heat or cold are as effective as those performed by therapists." Per the CA MTUS chronic pain guidelines, "The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments had less pain and less disability." Rationale for not using off the shelf simple hot/cold packs versus a hot/cold therapy unit is not specified in the records provided. Response to previous conservative therapy including physical therapy and pharmacotherapy is not specified in the records provided. The medical necessity of Hot/Cold Therapy Unit is not medically necessary for this patient.