

Case Number:	CM15-0102030		
Date Assigned:	06/04/2015	Date of Injury:	02/17/2006
Decision Date:	07/02/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/27/2015

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: Arizona, 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:

The injured worker is a 63-year-old male, who sustained an industrial injury on 2/17/06. The injured worker has complaints of left lumbar, left sacroiliac, lumbar, right lumbar, right sacroiliac, sacra, right pelvic, left buttock, left posterior leg, left posterior knee, left calf, left ankle, right buttock, right posterior leg, right posterior knee, right calf, right ankle, right foot, right hip, right anterior left, right anterior knee, right shin, right ankle, right foot, left hip, left anterior leg, left anterior knee, left shin, left ankle and left foot pan. The documentation noted that the injured worker has palpable tenderness at lumbar, left sacroiliac, right sacroiliac, left buttock and right buttock. The diagnoses have included intervertebral disc disorder with myelopathy, lumbar region and sciatica. Treatment to date has included magnetic resonance imaging (MRI) of the lumbar spine in 2011; pain cream and physical therapy. The request was for magnetic resonance imaging (MRI) of the lumbar spine; purchase of lumbar spine brace and interferential stimulator unit times 60 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar - MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According to the ACOEM guidelines, an MRI of the lumbar spine is recommended for red flag symptoms such as cauda equina, tumor, infection, or uncertain neurological diagnoses not determined or equivocal on physical exam. There were no red flag symptoms. There was no plan for surgery. The claimant had a prior MRI in 2011 and the request for another was only based on needing an "update." The request for an MRI of the lumbar spine is not medically necessary.

Purchase of Lumbar spine brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: According to the ACOEM guidelines, lumbar supports have not been shown to provide lasting benefit beyond the acute phase of symptom relief. In this case, the claimant's injury was remote and symptoms were chronic. The length of use was not specified. The purchase of a back brace is not medically necessary.

Interferential stimulator unit x 60 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines interferential unit Page(s): 118.

Decision rationale: Interferential unit is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. In this case, there was no mention of applying complementary interventions with an IF unit. Response to a month use is unknown before allowing for 2 months. The request for 60 days of an IF unit is not medically necessary.