MAXIMUS Federal Services

Case Number:	CM15-0138202		
Date Assigned:	07/28/2015	Date of Injury:	01/05/1981
Decision Date:	09/02/2015	UR Denial Date:	07/13/2015
Priority:	Standard	Application Received:	07/16/2015

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: Texas, New York, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 applicant is a represented [redacted] beneficiary who has filed a claim for chronic low back pain (LBP) reportedly associated with an industrial injury of January 5, 1981. In a Utilization Review report dated July 13, 2015, the claims administrator failed to approve a request for Zero Gravity Chair and an H-wave device. The claims administrator referenced an RFA form dated July 7, 2015 in its determination. On said July 7, 2015 RFA form, lumbar spine x-rays, a Zero Gravity Chair, an H-wave unit, and a lumbar support were endorsed. In an associated progress note dated June 27, 2015, the applicant reported ongoing complaints of low back pain status post earlier lumbar fusion surgery on May 8, 2015. The applicant stated that his leg symptoms had resolved and his axial complaints were also somewhat improved. A Zero Gravity Chair for back pain was sought in the event of flares of the same. An "electrotherapeutic unit" was endorsed, as was the lumbar support in question.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zero gravity chair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 9. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Durable medical equipment (DME) and Other Medical Treatment Guidelines ACOEM Occupational Medicine Practice Guidelines, 3rd ed., Low Back Disorders, pg. 527 2. Recommendation: Other Sleeping Surfaces for Treatment of Low Back Pain There is no recommendation for or against the use of optimal sleeping surfaces (e.g., bedding, water beds, and hammocks) for treatment of low back pain. It is recommended that patients select mattresses, pillows, bedding, or other sleeping options that are most comfortable for them. Strength of Evidence: No Recommendation, Insufficient Evidence (I).

Decision rationale: No, the proposed Zero Gravity Chair was not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 1, page 9 does acknowledge that all seatings should be fully adjustable to accommodate work at different heights and body habits, here, however, the applicant's work status was not detailed on June 26, 2015 office visit at issue. It did not appear that the applicant was working, however, either as result of the applicant's chronic pain complaints or as a result of age (76). It was not clearly stated, furthermore, why the Zero Gravity Chair would necessarily be desirable in the clinical context present here. The Third Edition ACOEM Guidelines Low Back Chapter also notes that there is no recommendation for or against usage of optimal sleeping surfaces such as bedding, waterbeds, mattresses, pillows, etc. By analogy, there is no recommendation for or against usage of any one particular chair over another as there is no evidence that provision of this particular chair would necessarily ameliorate the applicant's low back pain complaints. Finally, ODG's Knee Chapter durable medical equipment topic notes that one of the definitions of durable medical equipment is evidence that said equipment is primarily and customarily used to serve a medical purpose. Here, this particular brand of chair, a Zero Gravity Chair, does not necessarily serve a medical purpose as it can (and often is) used by individuals without a specific medical issue or medical diagnosis. Therefore, the request was not medically necessary.

H-Wave unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT) Page(s): 117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT) Page(s): 118.

Decision rationale: Similarly, the request for an H-wave device was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 118 of the MTUS Chronic Pain Medical Treatment Guidelines, provision of an H-wave device on a purchase basis should be justified by documentation submitted for review, with evidence of a favorable outcome during an earlier one-month trial of the same, in terms of "pain relief and function." Here, however, the H-wave device in question was sought via an RFA form of July 7, 2015 and an associated

progress note of June 26, 2015. It appears, however, that the treating provider had prescribed and/or dispensed the H-wave device without having the applicant first undergo a one-month trial of the same. Therefore, the request was not medically necessary.