

Case Number:	CM15-0143043		
Date Assigned:	08/04/2015	Date of Injury:	09/15/2014
Decision Date:	09/16/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/24/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 34-year-old female who sustained an industrial injury on 9-15-14. Her initial symptoms and exact nature of the injury are unavailable for review. On a follow-up medical appointment dated 12-5-14, the records indicate that she complains of "dull" back pain in the lumbar region. She reports that the severity is "moderately severe" and the frequency is constant. Her symptoms are exacerbated by movement and working. The record indicates that her symptoms are "lessened by n-a". The record indicates that she reports that the pain radiates to the back of her left leg, however, goes on to describe the radiating pain as "sharp" and indicates that it radiates to her kneecap and lower leg. Other symptoms include weakness, fatigue, loss of appetite, headaches, neck pain, and muscle aches. Her blood pressure was 93 over 56 with a pulse of 85. Her average pain rating is 4 out of 10. She was diagnosed with Degenerative Disc Disease, Lumbar Sprain, Strain, and Lumbar Herniated Disc. She was treated conservatively with medications. However, these were discontinued on the 12-5-14 office visit. She was referred to PMR to evaluate the need for steroid injections. The injured worker has not lost any work time since the injury, however, had been placed on modified duty with restrictions limiting standing or walking, stooping and bending, weight lifting up to 10 pounds, and frequent position changes. She was informed that she "must wear back support". Other restrictions were that she is only allowed to work 4 hours per day.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro IF unit and supplies rent to purchase (unknown DOS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120 of 127.

Decision rationale: Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.

Retro LSO Brace (unknown DOS): 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): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports.

Decision rationale: Regarding the request for lumbar brace, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state the lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. ODG goes on to state that for nonspecific low back pain, compared to no lumbar support, elastic lumbar belt maybe more effective than no belt at improving pain at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However, the evidence was very weak. Within the documentation available for review, it does not appear that this patient is in the acute or subacute phase of his treatment. Additionally, there is no documentation indicating that the patient has a diagnosis of compression fracture, spondylolisthesis, or instability. As such, the currently requested lumbar brace is not medically necessary.

Retro Cold Spot Gel (unknown DOS): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/Heat Packs.

Decision rationale: Regarding the request for Retro Cold Spot Gel (unknown DOS), California MTUS and ODG do not specifically address the issue for the low back, although ODG supports cold therapy units for up to 7 days after surgery for some other body parts. For the back, CA MTUS/ACOEM and ODG recommend the use of cold packs for acute complaints. Within the documentation available for review, there is no documentation of a rationale for the use of Retro Cold Spot Gel (unknown DOS) rather than the application of simple cold packs at home. In the absence of such documentation, the currently requested Retro Cold Spot Gel (unknown DOS) is not medically necessary

Retro back knobber (unknown DOS): 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), Knee, Durable Medical Equipment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Durable medical equipment (DME).

Decision rationale: Regarding the request for Retro back knobber (unknown DOS), California MTUS does not address the issue. ODG states certain DME toilet items (commodes, bed pans, etc.) are medically necessary if the patient is bed- or room-confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. Within the documentation available for review, there is no indication as to what this device would be used for, and why the patient would be unable to achieve similar results without the use of this device using a program of stretching and strengthening. In the absence of clarity regarding those issues, the currently requested Retro back knobber (unknown DOS) is not medically necessary.