

Case Number:	CM15-0164740		
Date Assigned:	09/02/2015	Date of Injury:	03/12/2013
Decision Date:	10/06/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/24/2015

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: North Carolina

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 56 year old female who sustained an industrial injury on 3-12-13. Her initial complaints included pain when bending, walking or prolonged sitting. She sustained the injury due to slipping, resulting in a fall. The 7-22-15 Doctor's First Report of Occupational Injury or Illness indicates diagnoses of Grade I mobile spondylolisthesis L4-5 with instability, as well as left hand surgery - type unknown. Her noted complaints were of lumbar back pain radiating to bilateral lower extremities, affecting the right greater than the left, as well as left hand pain. X-rays and an MRI were completed. On examination, she was noted to have decreased strength sensations on right L5, decreased range of motion in the lumbosacral spine with "posterior tenderness and spasms", and she was noted to have the inability to "heel walk" bilaterally. The treatment recommendation was for surgery - anterior lumbar decompression and instrumented fusion at L4-5 with allograft bone, interbody cage, and anterior plating. The documentation indicated that she would require "a LSO postoperatively". A polar care unit for modulation of heat and cold postoperatively, as well as a muscle stimulator for muscle reeducation and a bone stimulator to increase the rate of lumbar fusion were recommended for the postoperative period. The report indicates that she "has failed DC, PT, acupuncture, injections, and medications over 2 years of time". Her medications included Naproxen, Cyclobenzaprine, and Tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME Muscle Stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-117.

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

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested item. Per the Official Disability Guidelines section on durable medical equipment, DME is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. DME equipment is defined as equipment that can withstand repeated use i.e. can be rented and used by successive patients, primarily serves a medical function and is appropriate for use in a patient's home. The requested DME does not serve a purpose that cannot be accomplished without it. The prescribed equipment does not meet the standards of DME per the ODG. Therefore the request is not medically necessary.