

Case Number:	CM15-0038818		
Date Assigned:	03/09/2015	Date of Injury:	06/30/2014
Decision Date:	07/02/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	03/02/2015

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: New York
 Certification(s)/Specialty: Pediatrics, Internal 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 injured worker is a 49 year old female, who sustained an industrial injury on 6/30/14. She reported neck, left shoulder and lower back injury. The injured worker was diagnosed as having whiplash sprain/strain, lumbar sprain/strain and lumbosacral IVD displacement. Treatment to date has included (MRI) magnetic resonance imaging of lumbar spine, physical therapy, acupuncture and Norco. Currently, the injured worker complains of low back pain. The current treatments requested include surgical consult, pain management and lumbosacral back brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral to Pain Management: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs Page(s): 30-32.

Decision rationale: Indications for referral to pain management include all of the following: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. The documentation provided did not note any of the indications for pain management referral. This request is not medically necessary and appropriate.

Surgical Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

Decision rationale: ACOEM guidelines state that referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, or activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms or clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair or a failure of conservative treatment to resolve disabling radicular symptoms. With regards to the IW there is an MRI from December 2014 that shows some foraminal narrowing at the L3-4, L4-5 and L5-S1 levels however, the requesting physician noted no neurologic deficit in the lower extremities. The request is not medically necessary.

LSO Back Brace: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: According to ACOEM guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The ODG guidelines state that lumbar supports are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). The IW has diagnoses of lumbar sprain/strain, which is not an indication for bracing/supports. The request is not medically necessary and appropriate.

X-Force Stimulator with supplies x 90 day trial: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy; TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-115.

Decision rationale: Per MTUS guidelines, TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for neuropathic pain, phantom limb pain, spasticity and multiple sclerosis. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. The IW has none of the conditions as an indication for TENS uses and is not doing physical therapy and thus the request is not medically reasonable and appropriate.

Solar Care heating system (for Purchase): 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Cold/heat packs.

Decision rationale: Per ODG, Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The documentation does not note that the IW had tried application of heat packs at home previously with temporary improvement indicating that the continuous therapy would be beneficial. Additionally, the recommendations are for acute pain and the IW was injured more than 6 months prior to the request, which is outside of the acute time period.