MAXIMUS Federal Services

Case Number:	CM14-0140132		
Date Assigned:	09/08/2014	Date of Injury:	07/09/2013
Decision Date:	10/16/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	08/29/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 35-year old male whose date of injury is 07/09/2013. The injured worker was picking up his toolbag and while coming back up, he felt a sharp pain in his lower back. Diagnoses are lumbar disc disorder, lumbar neuritis, segmental dysfunction of the cervical spine, segmental dysfunction of the thoracic spine, sacroilitis and myospasms. Office visit note dated 07/19/14 indicates that on physical examination deep tendon reflexes are 1+ bilateral patella and 2+ bilateral Achilles. The injured worker was recommended for chiropractic treatment, back brace and Prostim unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pro-Stim Unit x 30 day trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 114, 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Transcutaneous electrotherapy, Page(s): pages 114-117.

Decision rationale: Based on the clinical information provided, the request for Pro-stim unit x 30 day trial is not recommended as medically necessary. There are no specific, time-limited treatment goals provided in accordance with CA MTUS guidelines. There is no clear rationale

provided to support the requested trial. Therefore, Pro-Stim Unit x 30 day trial is not medically necessary.

Kronos Lumbar Pneumatic Back Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 298 and 301. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation) Low Back Chapter, Lumbar supports

Decision rationale: Based on the clinical information provided, the request for Kronos lumbar pneumatic back brace is not recommended as medically necessary. The Official Disability Guidelines note that lumbar supports are not recommended for prevention of low back pain. There is no documentation of instability, compression fracture or spondylolisthesis as required by the Official Disability Guidelines. Therefore, Kronos Lumbar Pneumatic Back Brace is not medically necessary.

Chiro Manipulation, Electrical Muscle Stimulation, Diathermy, Myofascial Release x6-8: 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 Manual therapy and manipulation, Page(s): pages 58-60.

Decision rationale: Based on the clinical information provided, the request for Chiro manipulation, electrical muscle stimulation, diathermy and myofascial release x 6-8 is not recommended as medically necessary. The number of sessions completed to date and the injured worker's objective functional response to treatment are not documented to establish efficacy of treatment. There is no clear rationale provided to support passive modalities at this point in the injured worker's treatment. There are no specific, time-limited treatment goals provided. CA MTUS guidelines would support 1-2 visits every 4-6 months for recurrence/flare-up and note that elective/maintenance care is not medically necessary.