

Case Number:	CM14-0157872		
Date Assigned:	10/01/2014	Date of Injury:	10/12/2005
Decision Date:	11/25/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	09/26/2014

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 Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 65 year old employee with date of injury of 10/12/2005. Medical records indicate the patient is undergoing treatment for s/p right total knee replacement (7/08); left total knee replacement (10/08) and bilateral facet rhizotomy at L3-L4 and L4-L5 (undated). He has been diagnosed with lumbosacral musculoligamentous sprain and strain with two to three millimeter disc protrusions at L3-L4, L4-L5 and L5-S1 with hypertrophy. He is s/p GI endoscopy on 4/14. He has major depressive disorder, single episode and partial remission. He has peptic ulcer disease (pre-existing) with industrial aggravation secondary to anxiety and stress. Subjective complaints include pain and back spasm which caused difficulty sleeping. His low back pain radiates to the bilateral legs and feet. Objective findings include tenderness to palpation over the lumbar spine at the lumbosacral junction. The patient's range of motion (ROM) was limited in all planes. His straight leg test was positive and caused pain. He had axial pain with extension. Treatment has consisted of a ring cushion, HEP (home exercise program), electrical muscle stimulator, acupuncture, Marinol, Norco, Lisinopril, Hydrocodone, Omeprazole and Xanax. The utilization review determination was rendered on 9/18/2014 recommending non-certification of Retro: Ring Cushion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: Ring Cushion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back (updated 8/22/14)- Mattress Selection

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, Lumbar Support and on Other Medical Treatment Guideline or Medical Evidence:
<http://www.ncbi.nlm.nih.gov/pubmed/23826832>

Decision rationale: ODG states "Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (low back pain) (very low-quality evidence, but may be a conservative option). Is under study for post-operative use". ODG also states, "Not recommended for prevention". A recent study of lumbar supports concluded "future work is required to determine clinical relevance over the long term". The evidence based medicine only supports the use of lumbar supports with evidence of a compression fracture, spondylolisthesis, or documented instability. The treating physician has not provided documentation to meet ODG guidelines. As such, the request for Retro: Ring Cushion is not medically necessary at this time.