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| Case Number: | CM14-0085845 | | |
| Date Assigned: | 07/23/2014 | Date of Injury: | 09/30/2013 |
| Decision Date: | 09/24/2014 | UR Denial Date: | 05/30/2014 |
| Priority: | Standard | Application Received: | 06/09/2014 |

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 Family Medicine and is licensed to practice in California. 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 31 year old male who sustained injury to his low back on 09/30/13 due to slip and fall. 12/02/13 MRI of the lumbar spine revealed minimal to mild spondylosis at L5-S1 and to a lesser extent at L4-5; no significant stenosis and the remainder of the lumbar disc levels was unremarkable. 03/17/14 progress note reported reduced range of motion in the lumbar spine secondary to pain. EMG/NCV revealed left chronic active L4-5 radiculopathy. Progress note dated 04/28/14 was handwritten and difficult to decipher. Physical examination noted reduced range of motion in the lumbar spine with spasms and negative straight leg raise.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi Stimulation unit plus supplies 5 month rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Previous request was denied on the basis that current evidence based guidelines do not recommend the use of devices combining electrotherapy modalities that are not

recommended individually. In addition, guidelines do not consistently recommend interferential, NMS, and galvanic electrotherapy. Most recent progress note was mostly illegible and there was no documentation of rationale identifying why combine electrotherapy unit would be required as opposed to a TENS unit. The CAMTUS states that while TENS may reflect the longstanding accepted standard of care within many medical communities, the results of studies are inconclusive; published trials do not provide information on stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long term effectiveness. Several published evidence based assessments of TENS have found that evidence is lacking concerning effectiveness. Given this, the request for multi stimulation unit plus supplies times five month rental is not indicated as medically necessary.

Heat / Cold unit 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) Aqua Relief System. Knee and Leg (updated 02/15/2012).

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 chapter, Cold/heat packs.

Decision rationale: The request for heat/cold unit purchase is not medically necessary. Previous request was denied on the basis that continuous flow cryotherapy is recommended as an option after surgery, but not for non-surgical treatment. Post-operative use generally may be up to seven days, including home use. In addition, the Official Disability Guidelines state that while there are studies on continuous flow cryotherapy, there are no published high quality studies on any combined system. It was not noted that the injured worker is in the post-operative period after reviewing the submitted clinical documentation, there was no additional significant objective clinical information provided that would support reversing the previous adverse determination. Given this, the request for heat/cold unit purchase is not indicated as medically necessary.

LSO Back Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-Low Back Chapter.

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 chapter, Lumbar supports.

Decision rationale: The injured worker had a 2013 date of injury and was well past the acute phase of this injury. There was no documentation for compression fractures as specific treatment of spondylolisthesis, documented instability. The Official Disability Guidelines recommended conditions for a back brace. The Official Disability Guidelines state that there is strong and

consistent evidence that lumbar supports were not effective in preventing neck pain and back pain. Current evidence based studies on preventing episodes of back problems found strong, consistent evidence that exercises interventions are effective and other interventions are not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. These studies concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low back pain. There was no evidence of any instability or that the injured worker underwent recent fusion. Given this, the request for LSO back brace is not indicated as medically necessary.

Lumbar Home Exercise Rehab Kit: 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 Chapter:Exercise Equipment.

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 chapter, Durable medical equipment.

Decision rationale: Previous request was denied on the basis that before the requested exercise kit could be considered medically appropriate, the injured worker must be taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit is needed. The Official Disability Guidelines state that exercises equipment is considered not primarily medical in nature and that DME can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the home of the patient. The most recent clinical note was illegible and made no mention regarding the contents of the exercise rehab kit or indications for its use. After reviewing the submitted clinical documentation, there was no significant objective clinical information provided that would support reversing the previous adverse determination. Given this, the request for lumbar home exercise rehab kit is not indicated as medically necessary.