

Case Number:	CM14-0215631		
Date Assigned:	01/05/2015	Date of Injury:	12/23/2013
Decision Date:	03/04/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	12/23/2014

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. 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: Texas, California
 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:

This is 28 year old male patient who sustained a work-related injury on December 23, 2013. The diagnoses include lumbar spine radiculitis and lumbar spine discopathy. He sustained the injury due to stack of tray collapsed and fell on top of him. Per the doctor's note dated August 25, 2014 he had complaints of constant low back pain with radiation to the buttocks and legs with numbness, tingling and muscles spasms and noted minimal improvement in his condition. Per the doctor's note dated October 31, 2014, he had complaints of moderate to severe low back pain at 9/10 associated with muscle spasms, tingling, numbness and radiation of pain to the legs. The pain continued to increase with repetitive bending, stooping, prolonged walking, standing and sitting. Physical examination revealed tenderness to palpation over L3-S1 and the associated paralumbar muscles. The medications list includes mobic, relafen and tramadol. He has undergone lumbar epidural steroid injections on May 22, 2014 and August 19, 2014. He has had an x-ray of the lumbar spine on December 24, 2013 which revealed normal findings. He has had chiropractic therapy visits and cold/hot therapy pack for this injury. The evaluating physician requested an IF Unit to manage pain at home and an LSO lumbar brace for support. The injured worker's work status was defined as Total Temporary Disability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of a LSO Lumbar Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) LSO

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Work relatedness and Page 298.

Decision rationale: Request: Q-1-Purchase of a LSO Lumbar Brace Per the ACOEM guidelines, there is no evidence for the effectiveness of lumbar supports. Therefore, cited guidelines do not recommend lumbar support for low back pain. Evidence of a recent lumbar fracture, spondylolisthesis, recent lumbar surgery or instability was not specified in the records provided. In addition, response to previous conservative therapy including physical therapy is not specified in the records provided. The medical necessity of Purchase of a LSO Lumbar Brace is not fully established for this patient.

Purchase of Interferential Stimulator IF Unit and Supplies: 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 Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): Page 118-120..

Decision rationale: Request: Purchase of Interferential Stimulator IF Unit and Supplies Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) is Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Per the cited guideline while not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. There is no evidence of failure of conservative measures like physical therapy for this patient. Any evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse is not specified in the records provided. The medical necessity of Purchase of Interferential Stimulator IF Unit and Supplies is not fully established for this patient at this juncture.

