

Case Number:	CM15-0115727		
Date Assigned:	06/24/2015	Date of Injury:	09/13/2006
Decision Date:	07/29/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/16/2015

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: California, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 39 year old male who sustained an industrial injury on 09/13/06. Initial complaints and diagnoses are not available. Treatments to date include medications, conservative care, and home exercise program. Diagnostic studies are not addressed. Current complaints include low back pain. Current diagnoses include lumbar radiculitis, myofascial pain, and lumbar disc displacement. In a progress note dated 05/27/15 the treating provider reports the plan of care as unspecified medications, weight loss/diet, home exercise program, non-steroidal anti-inflammatory medications, ice, a lumbosacral orthotic brace for support of the lumbar spine, a TENS unit for home use, and an Aqua Therapy unit for home use. The requested treatments include a lumbosacral orthotic brace for support of the lumbar spine, a TENS unit for home use, and an Aqua Therapy unit for home use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aqua relief system (hot and cold) pump: Upheld

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

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

Decision rationale: The attending physician report dated 5/27/15 indicates the patient complains of ongoing lower back pain. The current request is for an aqua relief system (hot and cold) pump. The ODG does recommend hot/cold packs as an option for acute pain. Studies have not shown superiority of motorized hot and cold units. The attending physician report dated 5/27/15, page 24 (b), indicates the physician is requesting an aqua relief (hot and cold) pump for home use lumbar. In this case, studies have not shown superiority with motorized hot/cold units over conventional hot/cold packs, other than convenience. Records do not indicate the patient is having an acute episode. The available records do not support this request and an aqua relief system is not medically necessary.

Lumbar-sacral orthosis back brace with lateral support: Overturned

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

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

Decision rationale: The attending physician report dated 5/27/15 indicates the patient complains of ongoing lower back pain. The current request is for Lumbar sacral orthosis back brace with lateral support. The attending physician report dated 5/27/15, page 24 (b), indicates the physician is requesting an LSO brace for support of the lumbar spine. The ODG does recommend lumbar supports as an option for compression fractures, and specific treatment of spondylolisthesis with documented instability and for treatment of nonspecific LBP. In this case, the patient did not suffer a compression fracture, is not being treated for spondylolisthesis or instability but does have non specific lower back pain. The available medical records establish medical necessity for the request of a lumbar sacral orthosis back brace with lateral support. The current request is medically necessary.

Transcutaneous electrical nerve stimulator unit with leads and wires: 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 TENS Page(s): 114.

Decision rationale: The attending physician report dated 5/27/15 indicates the patient complains of ongoing lower back pain. The current request is for Transcutaneous electrical nerve stimulator unit with lead and wires. The attending physician report dated 5/27/15, page 24 (b) notes that the TENS unit is requested for home use. Per MTUS guidelines, TENS units have no proven efficacy in treating chronic pain and are not recommend as a primary treatment modality, but a one month home based trial may be considered for specific diagnosis of neuropathy, CRPS,

spasticity, phantom limb pain, or Multiple Sclerosis. In this case, there is no discussion of a one month trial period of TENS which documents functional benefits or decreased pain levels. The available medical records do not establish medical necessity for the above request. The current request for a TENS unit is not medically necessary.