MAXIMUS Federal Services

Case Number:	CM15-0170535		
Date Assigned:	09/11/2015	Date of Injury:	09/04/2012
Decision Date:	10/08/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	08/31/2015

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: Arizona, 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:

The injured worker is a 49-year-old female, who sustained an industrial-work injury on 9-4-12. She reported initial complaints of pain to left wrist, left hip, and back due to repetitive use. The injured worker was diagnosed as having degenerative disc disease, lumbar area, sciatica, and unspecified myalgia and myositis. Treatment to date has included medication. Currently, the injured worker complains of pain in the left hip, low back, and both shoulders, left heel and left buttock. Pain is constant, sharp, shooting, and throbbing, radiates to the back and left shoulder and hip. Average pain is 6 out of 10 and made worse by lifting and activity. Current medication is Norco, Cymbalta, hydrochlorothiazide, and Ibuprofen. Per the primary physician's progress report (PR-2) on 7-30-15, vital signs were stable and meds were being refilled for pain control. Current plan of care includes medication refill and Precor decompression machine. The Request for Authorization date was 8-5-15 and requested service included Precor Decompression Machine. The Utilization Review on 8-12-15 denied due to lack of support by the per ODG (Official Disability Guidelines) Low Back Chapter guidelines. There was no documentation of any physical exam in the last 2 progress notes or home exercise program and symptoms are helped with medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Precor Decompression Machine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, Lumbar & Thoracic (Acute & Chronic) - Traction.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Inital Care, Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter and pg 19.

Decision rationale: Decompression devices with the intention to perform similar intervention as traction or axial decompression is not supported nor recommended by the guidelines. In this case, the claimant is receiving pain medications. Use of therapy, exercises and medications has more proven benefit than traction. As a result, the request for Precor Decompression is not medically necessary.