

Case Number:	CM15-0061811		
Date Assigned:	04/07/2015	Date of Injury:	11/23/2010
Decision Date:	06/01/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	04/01/2015

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, Arizona

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 47 year old male, who sustained an industrial injury on November 23, 2010. The diagnoses have included lumbar radiculopathy, lumbar central disc extrusion and chronic pain. Treatment to date has included medications, radiological studies, topical analgesics, epidural steroid injections, transcutaneous electrical nerve stimulation unit, chiropractic care, physical therapy and a home exercise program. Current documentation dated February 6, 2015 notes that the injured worker reported neck, mid back, low back, left shoulder, right knee and right ankle pain and ongoing headaches. The low back pain radiated to the right lower extremity. The injured worker's activities of daily living were limited due to the pain. Examination of the lumbar spine revealed tenderness, spasms and a severely limited range of motion secondary to pain. Sensation was decreased in the right lower extremity. A straight leg raise test was positive on the right. The injured worker was noted to have an antalgic gait. The treating physician's plan of care included a request for transcutaneous electrical nerve stimulation unit replacement pads # 4, lumbar support brace, Voltaren 1% gel, chiropractic therapy # 8 and a lumbar seat personal massager. A Request for Authorization Form was then submitted on 02/20/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit replacement pads, quantity 4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1-month home based trial may be considered as a noninvasive conservative option. In this case, it is noted that the injured worker has continuously utilized a TENS unit since at least 12/2014. There is no documentation of how often the unit is used as well as outcomes in terms of pain relief and function. The medical necessity for the ongoing use of a TENS unit has not been established in this case. Therefore, the request is not medically necessary.

Lumbar support brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: California MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. In this case, there was no documentation of spinal instability upon examination. The medical necessity for the requested lumbar support brace has not been established in this case. As such, the request is not medically necessary.

Voltaren 1% gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state the only FDA approved topical NSAID is Voltaren 1% gel, which is indicated for the relief of osteoarthritis pain. The injured worker does not maintain a diagnosis of osteoarthritis. In addition, the California MTUS Guidelines do not recommend Voltaren 1% gel for treatment of the spine. There is also no frequency or quantity listed in the request. As such, the request is not medically necessary.

Chiropractic, 8 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58; 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: California MTUS Guidelines recommend manual therapy and manipulation for chronic pain if caused by a musculoskeletal condition. Treatment for the low back is recommended as a therapeutic trial of 6 visits over 2 weeks. The current request for 8 sessions of chiropractic therapy would exceed guideline recommendations. It is also noted that the physician requested chiropractic therapy for the lumbar spine in 11/2014. Documentation of the previous course of treatment with evidence of significant functional improvement was not provided. The request as submitted also failed to indicate the specific body part to be treated. Given the above, the request is not medically necessary.

Lumbar Seat Personal Massager: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chiropractic Manual Therapy -Grondin DE, Triano JJ, Steve T. Soave D; Blue Cross of California Medical Policy Durable Medical Equipment CG-DME-10.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Durable Medical Equipment.

Decision rationale: The Official Disability Guidelines recommend durable medical equipment if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. In this case, there is no mention within the clinical documentation as to the purpose for the equipment. It is unclear how the requested item will significantly alter the injured worker's condition or treatment plan. The medical necessity has not been established in this case. Therefore, the request is not medically necessary at this time.