

Case Number:	CM13-0032799		
Date Assigned:	05/19/2014	Date of Injury:	07/12/2012
Decision Date:	06/13/2014	UR Denial Date:	09/03/2013
Priority:	Standard	Application Received:	10/08/2013

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 Orthopedic Surgeon and is licensed to practice in Maryland. 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 50 year old male who reported an injury to his low back when the shock absorber device on the vehicle he was driving malfunctioned and the seat bottomed out underneath him on 07/12/12. The injured worker reported severe levels of low back pain. The MRI of the lumbar spine dated 07/25/13 revealed a slight annular bulge at L4-5 with no evidence of herniation or stenosis. Evidence of a right side laminotomy was revealed at L5-S1 with a minimal central disc protrusion and minimal bilateral neural foraminal narrowing. A clinical note dated 07/31/13 indicated the injured worker complaining of low back pain radiating to the right lower extremity. The injured worker reported numbness, paresthesia, and weakness in the right leg. Upon exam, reflexes were identified as being absent at the right ankle. Sensation was decreased in right L5 distribution. Strength was 4-/5 in S1 distribution on the right. The injured worker was identified as having positive straight leg raise on the right with a markedly antalgic gait. The Agreed Medical Exam dated 12/13/13 indicated use of Norco, soma, and ibuprofen for pain relief. The injured worker continued to rate low back pain as 4-5/10. The injured worker had a current smoking habit of one half-pack per day. The injured worker was able to demonstrate 60 degrees of lumbar flexion, 10 degrees of extension, and 10 degrees of bilateral bending. Patrick's Test was positive on the right. The injured worker underwent X-rays of the lumbar spine which revealed no motion segment instability. The injured worker underwent right sided L5-S1 laminectomy in 2001. Note dated 02/25/14 indicated the injured underwent lumbar interbody fusion. A clinical note dated 03/21/14 left greater than right, lower extremity edema. The Duplex study on 03/19/14 revealed essentially normal examination. May 28, 2014, note indicated normal reflex, sensory, and strength testing in all extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOT/COLD THERAPY UNIT PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 308-310.

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, Continuous Cryo-Therapy.

Decision rationale: Clinical documentation indicates the injured worker undergoing L5-S1 fusion. The use of cold therapy is indicated for the low back. However, local at-home products are recommended over commercially available products as currently no high quality studies exist supporting the use of commercial products over the use of cold packs. Therefore, this request for Hot/Cold Therapy is not medically necessary.

BONE GROWTH STIMULATOR PURCHASE: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (Updated 5/10/2013) - Bone Growth Stimulators.

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, Bone Growth Stimulator.

Decision rationale: A bone growth stimulator is indicated for injured workers with one or more failed spinal fusions; grade three or worse spondylolisthesis; fusion to be performed at more than one level; the injured worker has a current smoking habit or has indications of diabetes, renal disease, or alcoholism or significant osteoporosis has been confirmed by radiographs. The clinical notes indicate the injured worker having a current smoking habit of one half pack per day. Given the current smoking habit the use of bone growth stimulator is medically necessary.

MUSCLE STIMULATOR 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), Low Back, Neuromuscular Electrical Stimulators.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation Page(s): 120-1.

Decision rationale: The use of a muscle stimulator purchase is not indicated. The use of neuromuscular electrical stimulation is generally indicated as part of the rehabilitation program following a stroke. No information was submitted regarding stroke history. Given this, the request for Muscle Stimulator is not medically necessary.

LOW BACK BRACE PURCHASE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

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, Back Brace.

Decision rationale: The clinical documentation indicates the injured worker undergoing L5-S1 fusion. Given the operative history, a back brace is indicated in order to provide the injured worker with additional stability in order to promote healing. Therefore, this request is reasonable. The request for back brace is medically necessary.