

Case Number:	CM13-0036783		
Date Assigned:	12/13/2013	Date of Injury:	08/05/2009
Decision Date:	06/24/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/21/2013

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 Anesthesia, has a subspecialty in Pain Medicine and is licensed to practice in California. 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:

This patient is a 53 year old male injured worker with date of injury 8/5/09 with related low back and leg pain. Per progress report, he had subjective complaints of ongoing low back, bilateral leg pain right greater than left, increased pain by walking. Physical exam revealed 3/5 strength in his right iliopsoas, quadriceps, hamstrings, dorsiflexors, extensor hallucis longus, and plantarflexors was limited by leg pain. He had 4/5 strength of muscle groups on the left side. Gait was slow and antalgic and he used a cane for assistance. Range of motion was limited of his back secondary to pain. The AP indicated the claimant presented with increased low back and bilateral leg pain related to the combination of L4-L5 degenerative disc disease, stenosis, spondylolisthesis, and bilateral knee problems. He has failed traditional nonsurgical treatment including physical therapy and pain management. The request L4-L5 laminectomy, bilateral facetectomies and transforaminal lumbar interbody fusion received authorization. MRI of the lumbar spine dated 6/27/13 revealed mild degenerative changes of the lumbar spine, 1mm broad-based posterior disc bulge at L4-L5. The date of UR decision was 9/30/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY UNIT WITH PAD AND STRAPS: 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

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, Continuous-flow cryotherapy.

Decision rationale: The MTUS is silent on the use of cold therapy units. The ODG states continuous-flow cryotherapy is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting." As the ODG only supports the use of cold therapy units for up to 7 days, purchase is not medically necessary.

SHOWER SEAT WITH BACK REST: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Bathtub Seats

Decision rationale: The MTUS is silent on shower seats. Per Official Disability Guidelines TWC, a shower seat with back rest is considered a comfort or convenience item, not durable medical equipment. According to Official Disability Guidelines (ODG) Procedure Summary "Bathtub seats are considered a comfort or convenience item, hygienic equipment, & not primarily medical in nature." Therefore the request is not medically necessary.

ROLLATOR: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Walking Aids

Decision rationale: Per Official Disability Guidelines TWC guidelines, walking aids are recommended. As the injured worker will undergo L4-L5 decompression and fusion, postoperative walker is indicated. However, a front wheel walker was already certified. As this request is duplicative, it is not medically necessary.

BONE GROWTH STIMULATOR: 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, 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, Bone growth stimulators

Decision rationale: The MTUS is silent on the use of bone growth stimulators. Per Official Disability Guidelines TWC with regard to bone growth stimulators, "Under study. There is conflicting evidence, so case by case recommendations are necessary (some RCTs with efficacy for high risk cases). Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases (e.g., revision pseudoarthrosis, instability, smoker). (Mooney, 1990) (Marks, 2000) (Akai, 2002) (Simmons, 2004). There is no consistent medical evidence to support or refute use of these devices for improving patient outcomes; there may be a beneficial effect on fusion rates in patients at "high risk", but this has not been convincingly demonstrated." "Criteria for use for invasive or non-invasive electrical bone growth stimulators: Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor); (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs." The documentation submitted for review does not indicate that the injured worker carries any risk factor for failed fusion. Therefore given the above the request is not medically necessary.

IF UNIT, DELIVERY AND SET-UP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: With regard to interferential current stimulation, the Chronic Pain Medical Treatment Guidelines, states: "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." A one month-trial may be appropriate if there is significant pain from postoperative conditions that limits the ability to perform exercise programs/physical therapy treatment, however, the documentation submitted for review do not contain evidence suggesting this to be the case. Therefore the request is not medically necessary.