

Case Number:	CM13-0043468		
Date Assigned:	12/27/2013	Date of Injury:	09/05/2008
Decision Date:	04/30/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	10/23/2013

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 Physical Medicine & Rehabilitation 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:

According to the records made available for review, this is a 47-year-old male with a 9/5/08 date of injury. At the time of request for authorization for a TENS unit, a hot/cold therapy unit, an airform back brace, there is documentation of subjective (back pain) and objective (lumbar paraspinous muscle spasm, tenderness to palpation over the lumbar spine, 4/5 motor strength over the right psoas and quadriceps, and negative sensation in the L3 and L4 dermatomes on the right) findings, current diagnoses (status post posterior lumbar interbody fusion at L4-5 and L5-S1, and herniated nucleus pulposus at L3-4 with right L4 radiculopathy), and treatment to date (medications). Medical reports identify a 10/14/13 microdiscectomy L3-4 and a request for TENS unit, Hot/cold unit, and an Airform back brace for post-operative use.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS UNIT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Post Operative Pain (Transcutaneous Electrical Nerve Stimulation). Page(s): 116-117.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies TENS unit as an option for acute post-operative pain in the first 30 days post surgery, most effective for mild to moderate thoracotomy pain, and of lesser effect, or not at all, for other surgical procedure. Within the medical information available for review, there is documentation of diagnoses of status post posterior lumbar interbody fusion at L4-5 and L5-S1, and herniated nucleus pulposus at L3-4 with right L4 radiculopathy. In addition, there is documentation of a 10/14/13 micro discectomy L3-4 and a request for TENS unit, Hot/cold unit, and an Air form back brace for post-operative use. Furthermore, there is no documentation of the number of days requested. Therefore, based on guidelines and a review of the evidence, the request for a TENS unit is not medically necessary.

HOT/COLD THERAPY UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, and Cold/heat packs. Other Medical Treatment Guideline or Medical Evidence: PMID: 18214217 Pub Med - indexed for MEDLINE.

Decision rationale: MTUS reference to ACOEM guidelines identifies at-home applications of local heat or cold to the low back as an optional clinical measure for evaluation and management of low back complaints. ODG identifies that there is minimal evidence supporting the use of cold therapy. Medical Treatment Guideline identifies that exact recommendations on application, for postoperative cold therapy utilization following lumbar spine surgery, on time and temperature cannot be given. Therefore, based on guidelines and a review of the evidence, the request for a hot/cold therapy unit is not medically necessary.

AIRFORM BRACK BRACE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar Support; Back Brace, post operative (fusion).

Decision rationale: MTUS reference to ACOEM identifies that lumbar support have not been shown to have any lasting benefit beyond acute phase of symptom relief. ODG identifies documentation of compression fractures, spondylolisthesis, or documented instability, as criteria necessary to support the medical necessity of lumbar support. ODG also notes that post operative back brace is under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician. Within the medical information available for review, there is documentation of diagnoses of status post posterior lumbar interbody fusion at

L4-5 and L5-S1, and herniated nucleus pulposus at L3-4 with right L4 radiculopathy. In addition, given documentation of a 10/14/13 micro discectomy L3-4, there is documentation of a condition for which a standard brace would be indicated. Therefore, based on guidelines and a review of the evidence, the request for air form back brace is medically necessary.