

Case Number:	CM13-0046385		
Date Assigned:	06/09/2014	Date of Injury:	10/25/2012
Decision Date:	08/08/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	11/12/2013

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 and Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 38-year-old female with a date of injury of 10/25/2012. The listed diagnoses by [REDACTED] are: 1. L4-L5 right-sided stenosis. 2. L4-S1 moderate disk degeneration. 3. L4-S1 annular tear. 4. L4-L5 disk herniation. 5. Right leg radiculopathy. The medical file provided for review includes 1 progress report. According to report 04/29/2013 by [REDACTED], patient presents with complaints of low back pain which extends to the right hip, buttock, and down the right leg to the top of her foot. She complains of sharp, shooting pain down her right leg, which wraps around the front of her thigh mostly with sitting and standing. Patient reports, "At this point, nothing helps relieve her symptoms." It was noted the patient uses a "therapy ice machine" and lets it run on her back until she falls asleep. MRI of the lumbar spine from 01/15/2013 revealed L4-L5 lateral recess stenosis and L4-S1 moderate disk degeneration. There is an annular tear at L4-S1. Treater reports the patient is "unable to live with her pain." The treater is recommending a right L4-L5 microdiscectomy, cold therapy unit, interferential therapy stimulator, back support, and home exercise kit. Utilization review denied the request on 10/07/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG).

Decision rationale: This patient presents with chronic low back pain which extends to the right hip, buttock, and down the right leg to the top of her foot. On 4/29/2013 the treater recommended a right L4-L5 microdiscectomy and cold therapy unit for postoperative care. According to the utilization review from 10/07/2013, the patient underwent the microdiscectomy on 06/13/2013. The treater is requesting cold therapy for postoperative use but does not specify duration of recommended use. The California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) guidelines do not discuss cold therapy units. Therefore, Official Disability Guidelines (ODG) Guidelines are referenced. ODG Guidelines has the following regarding continuous-flow cryotherapy: 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 use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated. The ODG Guideline recommends the duration of postoperative use of continuous-flow cryotherapy to be 7 days. The use of the cold therapy unit outside of the postoperative 7 days is not medically necessary, and given there are no discussions on the duration of use, the requested treatment is not medically necessary and appropriate.

INTERFERENTIAL THERAPY (IF) STIMULATOR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM GUIDELINES CHAPTER ON CHRONIC PAIN, INTERFERENTIAL CURRENT STIMULATION, 189.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines.

Decision rationale: This patient presents with chronic low back pain which extends to the right hip, buttock, and down the right leg to the top of her foot. On 4/29/2013 the treater recommended a right L4-L5 microdiscectomy and Interferential therapy Unit for postoperative care. According to the utilization review from 10/07/2013, the patient underwent the microdiscectomy on 06/13/2013. The California Medical Treatment Utilization Schedule (MTUS) Guidelines page 118 to 120 states interferential current stimulation is 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. The randomized trials that have evaluated the effectiveness of this treatment have included the studies for back pain, jaw pain, soft tissue shoulder pain, cervical pain, and post-operative knee pain. For indications, MTUS mentions intolerability to meds, post-operative pain, history substance abuse, etc. For these indications, a one-month trial is then recommended. In this case, the treater's request lacks duration and time-frame and the IF unit is not recommended until a successful home trial for one-month. The requested treatment is not medically necessary and appropriate.

BACK SUPPORT: Upheld

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

MAXIMUS guideline: The Expert Reviewer based his/her decision on the the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12 Low Back Complaints, page 301 and on the Official Disability Guidelines (ODG).

Decision rationale: This patient presents with chronic low back pain which extends to the right hip, buttock, and down the right leg to the top of her foot. On 4/29/2013 the treater recommended a right L4-L5 microdiscectomy and a back brace for postoperative care. According to the utilization review from 10/07/2013, the patient underwent the microdiscectomy on 06/13/2013. The American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) guidelines page 301 on lumbar bracing states, Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The Official Disability Guidelines (ODG) guidelines regarding lumbar support states, Not recommended for prevention; however, recommended as an option for compression fracture and specific treatment of spondyloisthesis, documented instability, and for treatment of nonspecific low back pain (very low-quality evidence, but may be a conservative option). In this case, the patient does not present with fracture, documented instability or spondylolisthesis to warrant lumbar bracing. The requested treatment is not medically necessary and appropriate.

HOME EXERCISE KIT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: The patient is status post microdiscectomy on 06/13/2013. The treater is requesting a home exercise kit. Utilization review denied the request stating home exercise equipment is generally not considered to be a durable medical equipment unless there is documented medical necessity based on evidence-based guidelines. The American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), and the Official Disability Guidelines (ODG) guidelines do not discuss home exercise kits for the lumbar spine. ACOEM guidelines page 309 under low back chapter recommends, low-stress aerobic exercise. ACOEM further states, There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. Although exercise is recommended, it is unclear as to what the home exercise kit encompasses. Without knowing what the kit details, one cannot make a recommendation regarding its appropriateness based on the guidelines. There is no discussion regarding what exercises are to be performed and what kind of monitoring will be done. The requested treatment is not medically necessary and appropriate.