

Case Number:	CM13-0056811		
Date Assigned:	12/30/2013	Date of Injury:	06/02/2011
Decision Date:	03/31/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	11/22/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology and Pain Management and is licensed to practice in Florida. 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 physician 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 60-year-old male who reported an injury on 06/02/2011 after he lifted a pallet, caused to fall, which in turn caused him to twist which reportedly caused injury to his left lower back and left knee. The patient's treatment history included activity modification, medications, physical therapy, and epidural steroid injections. The patient underwent an MRI in 09/2013 that documented the patient had a 2 to 3 mm anterolisthesis that caused moderately severe central and bilateral foraminal stenosis. The patient most recent clinical evaluation documented the patient had significant low back pain radiating into the left lower extremity with restricted lumbar range of motion secondary to pain in all planes. The patient's diagnoses included advanced degenerative disc disease at the L5-S1 and facet and ligament flavum hypertrophy at the L4-5 and L5-S1 with moderate central and bilateral foraminal stenosis with radiculopathy. The patient's treatment plan included and L4-5 laminectomy and posterior interbody fusion with instrumentation at the L4-S1 followed by postsurgical management to include a lumbar brace, a cold therapy unit, and a bone growth stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Cybertech lumbar brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, Back Brace, Postoperative (Fusion)

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 Chapter, Back Brace, Post Operative (Fusion)

Decision rationale: The retrospective request for a Cybertech lumbar brace date of service 10/10/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any evidence from the date of service that the requested surgical intervention had taken place. The American College of Occupational and Environmental Medicine does not support the use of back braces for low back injuries. Additionally, Official Disability Guidelines do not recommend the use of back braces in the postoperative management of a patient who has undergone a fusion. Although a fusion surgery is recommended, there is no documentation that this has taken place for the date of service 10/10/2013. As such, the retrospective request for a Cybertech lumbar brace date of service 10/10/2013 is not medically necessary or appropriate.

Retrospective cold compression therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee & Leg, Compression Garments

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous Flow Cryotherapy.

Decision rationale: The retrospective cold compression therapy unit for date of service 10/10/2013 is not medically necessary or appropriate. Official Disability Guidelines do recommend use of a cold compression therapy unit for patients who require postsurgical management. The clinical documentation submitted for review does provide evidence that a recommendation was made for surgical treatment for this patient. However, there was no clinical documentation from 10/10/2013 provided supporting that the requested surgery had taken place. Therefore, the need for postoperative surgical treatment to include a cold compression therapy unit cannot be determined. As such, the retrospective request for a cold compression therapy unit for date of service 10/10/2013 is not medically necessary or appropriate.

Retrospective DJO bone growth stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 Chapter, Bone Growth Stimulators

Decision rationale: The retrospective request for a DJO bone growth stimulator for date of service 10/10/2013 is not medically necessary or appropriate. Official Disability Guidelines recommend the use of as bone growth stimulator in the instance of 1 or more failed spinal fusions or a grade 3 or worse spondylolisthesis. The clinical documentation submitted for review does not provide any evidence that the patient has a grade 3 or worse spondylolisthesis. Additionally, the clinical documentation does recommend surgical intervention to include fusion. However, there is no documentation that this surgery has happened or the patient has failed to fuse. Therefore, the need for a bone growth stimulator is not clearly established. As such, the requested retrospective DJO bone growth stimulator for date of service 10/10/2013 is not medically necessary or appropriate.