

Case Number:	CM13-0066830		
Date Assigned:	01/03/2014	Date of Injury:	06/17/2011
Decision Date:	06/04/2014	UR Denial Date:	11/08/2013
Priority:	Standard	Application Received:	12/17/2013

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 Surgery 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 who was injured on 06/17/2011. She was changing linens of a hospital bed while the hospital patient was lying on the bed. The patient had to forcefully push the hospital patient forward both arms to prevent him from rolling towards her. Prior treatment history has included (list prior treatments). The patient underwent left hemilaminectomy, inferior lamina of L5; left hemilaminectomy, superior lamina of S1 and epidural injection, left L5-S1 on 10/15/2013. PR2 dated 11/07/2013 states the patient complains of low back pain. She underwent lumbar spine surgery on October 15. Her pain is much improved but still having soreness since surgery. She denies any numbness and tingling. She is scheduled to begin physical therapy for low back in about 2 weeks. She is currently not working. The patient can heel and toe rise with difficulty. She can squat without difficulty. She has good posture, normal curvature and the skin reveals a well healed surgical incision. There is tenderness of the lumbar spinous processes and lumbar paravertebral muscles. She has decreased range of motion of the lumbar spine. There is negative straight leg raise bilaterally. Motor strength is 5/5 in all muscle groups. Sensation is intact to light touch and pin prick. Diagnoses are lumbar spondylosis without myelopathy and lumbar/lumbosacral disc degeneration; lumbar radiculitis/thoracic radiculitis; sacroiliac ligament sprain/strain; and lumbar myofascial sprain/strain. The recommendations include the following: ice/heat to areas of discomfort as needed; home exercise program; over-the-counter non-steroidal anti-inflammatory and analgesic medications as needed; ibuprofen 800 mg; and proceed with physical therapy and follow-up per spine surgeon.

IMR ISSUES, DECISIONS AND RATIONALES

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

Q TECH DVT PREVENTION SYSTEM X 21 DAYS: 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), Shoulder Chapter, Continuous Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee And Leg, Venous Thrombosis and Antithrombotic Therapy and Prevention Of Thrombosis, 9th Ed: American College of Chest Physicians Evidence Based Clinical Practice Guidelines.

Decision rationale: The ODG (knee and leg) states "For patients undergoing THR or TKR, ACCP recommends the optimal use of mechanical thromboprophylaxis with the VFP (venous foot pump) or IPC (intermittent pneumatic compression) for patients with a high risk of bleeding. When the high bleeding risk decreases, ACCP recommends that pharmacologic thromboprophylaxis be substituted for or added to the mechanical thromboprophylaxis." The American College of Chest Physicians Evidence-Based Clinical Practice Guidelines, Prevention of VTE in Orthopedic Surgery Patients recommends the use of a compression device following a THA, TKA or major orthopedic surgery and increased risk of bleeding. There is no indication that a cold therapy unit would be medically necessary for this patient.

Q-TECH COLD THERAPY RECOVERY SYSTEM WITH WRAP X21 DAYS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 38.

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, Neck, Shoulder And Knee, Cryotherapy.

Decision rationale: The CA MTUS does not address the issue of a cold therapy system. The ODG, low back chapter for cryotherapy (cold/heat) packs is recommended as an option for acute pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. The shoulder and knee section address the need for a "system" after surgery. The guidelines state they are recommended for knees and shoulders after surgery for generally 7 days and have been proven to decrease pain, inflammation, swelling and narcotic usage. 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. ODG, neck also states it is not recommended in the neck but may be an option after shoulder surgery. The patient is status post hemilaminectomy. The guidelines do not support the use of a cooling system for this type of operation or the duration of the requested treatment. The request is not medically necessary.

APOLLO LSO 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, Lumbar Supports.

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, Lumbar Supports.

Decision rationale: The ACOEM, low back complaints, state lumbar supports do not have any lasting benefits beyond the acute stage. The ODG state lumbar supports are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). Under study for post-operative use. The requestor states the LSO back brace is to be used status post surgery so she can heal while minimalizing mobility and discomfort. The guides do not recommend the brace for these purposes. The Apollo LSO is not medically necessary.