

Case Number:	CM13-0069329		
Date Assigned:	01/03/2014	Date of Injury:	06/12/2010
Decision Date:	05/28/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/20/2013

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:

This 55-year-old male sustained an industrial injury on 6/12/10 relative to his employment as [REDACTED] with the [REDACTED]. Past medical history was positive for a C4-C7 hybrid cervical reconstruction. The 8/21/12 electrodiagnostic study findings were consistent with chronic S1 radiculopathy. The 10/21/13 AP report cited subjective complaints of low back pain extending into the lower extremities. Lumbar exam documented pain and tenderness across the iliac crest into the lumbosacral spine, guarded and restricted flexion and extension, L5 and S1 generalized weakness and numbness, and some dragging of his feet with occasional complaints of foot drop. The MRI findings showed bone-on-bone erosion at L5/S1, and L4/5, herniated nucleus pulposus and spondylosis with some neural compromise and facet hypertrophy. Surgery was recommended to include L4 to S1 posterior lumbar interbody fusion with realignment of the junctional kyphotic deformity. Post-operative DME was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

ICE UNIT: 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): 160-161. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004), LOW BACK CHAPTER (REVISED 2007), 160-161

Decision rationale: Under consideration is a request for an ICE unit. The California MTUS guidelines are silent regarding cold therapy devices. The ACOEM Revised Low Back Chapter recommends self-applications of low-tech cryotherapies for the management of acute lower back pain. Routine home use of high-tech devices for the treatment of low back pain is not recommended. Guideline criteria have not been met. There is no compelling reason to support the medical necessity of a cold therapy device for this patient versus a standard ice pack. Therefore, this request for an ICE unit is not medically necessary.

BONE STIMULATOR: Overturned

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

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 & THORACIC, BONE GROWTH STIMULATORS (BGS).

Decision rationale: Under consideration is a request for a bone stimulator. The California MTUS guidelines are silent regarding bone growth stimulators. The Official Disability Guidelines indicate that the use of bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion for patients with any of the following risk factors for failed fusion: one of more previous failed spinal fusion(s); grade III or worse spondylolisthesis; multilevel fusion; current smoking habit; diabetes, renal disease, or alcoholism; or significant osteoporosis. Guideline criteria have not been met. The current surgery has been approved for one level only. There is no evidence in the medical records reviewed of any risk factors for failed fusion. Therefore, this request for a bone stimulator is not medically necessary.

3-1 COMMUNE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: NATIONAL COVERAGE DETERMINATION FOR DURABLE MEDICAL EQUIPMENT: PUBLICATION # 100-3, 5/5/05.

Decision rationale: Under consideration is a request for a 3-1 commode. The California MTUS guidelines are silent regarding commodes. The National Coverage Determination Guidelines indicate that commodes may be covered if the patient is confined to the room or bed. "Room confined" means that the patient's condition is such that leaving the room is medically

contraindicated. Guideline criteria have not been met. There is no evidence that the patient will be room-confined during the post-operative period requiring a commode. There is no compelling reason presented to support the medical necessity of this durable medical equipment. Therefore, this request for a 3-1 commode is not medically necessary.