

Case Number:	CM14-0015941		
Date Assigned:	06/04/2014	Date of Injury:	04/02/2013
Decision Date:	07/11/2014	UR Denial Date:	01/30/2014
Priority:	Standard	Application Received:	02/07/2014

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 Neuromuscular Medicine and is licensed to practice in Maryland. 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 54 year old male who had a work injury dated 4/2/13. The diagnoses include L4-5 and L5-S1 disc herniations, left.2. L4-5 and L5-S1 instability, with retrolisthesis, L4-5 and L5-S1, with over 5 mm of motion noted on lateral flexion/extension studies. The patient was certified to have an anterior lumbar Decompression & Fusion L4-L5, L5-S1 with Allograft Bone, Interbody Cage, Anterior lumbar Plating on a prior utilization review dated 1/27/14. The issue under consideration is whether a hot/cold therapy unit for purchase and a muscle stimulator for purchase were medically necessary. Per documentation the patient had lumbar X-rays, dated 10/30/13, which showed complete collapse at the L5-S1 level. There was retrolisthesis at L4-5. There was greater than 5 millimeters of motion on lateral flexion/extension studies at L4-5 and L5-S1. A lumbar MRI, dated 1/9/14, which showed retrolisthesis with collapse at L5-S1 on the left with a disc herniation, There was degenerative disc disease (DOD) with a left L4-5 disc herniation. A 1/20/14 primary treating physician documentation states that the patient had extensive non-operative care to date, which included: medications, physical therapy, injections, and time and activity modification. Per documentation the patient had developed progressive neurological deficits and that the MRI correlated with his levels of radiculopathy. He indicated that there were no psychosocial confounders. An anterior lumbar decompression and fusion at L4-5 and L5-S1 with allograft bone, interbody cage and anterior lumbar plating with a 3 day stay, surgical assistant, medical clearance, back brace, bone growth stimulator, a hot/cold therapy unit, post-operative physical therapy and a muscle stimulator were recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOT/COLD CONTRAST THERAPY UNIT 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), Knee and Leg Chapter, Cryotherapy Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg-continuous-flow cryotherapy; Low back-cold/heat packs; Shoulder-continuous-flow cryotherapy.

Decision rationale: A hot/cold contrast therapy unit for purchase is not medically necessary per the ODG guidelines. The MTUS guidelines do not discuss a hot/cold contrast therapy unit. The ODG low back chapter does not discuss continuous cold cryotherapy. . The ODG low back chapter state that heat/cold packs are recommended as an option for acute pain. At-home local applications of cold pack in first few days of acute complaint; thereafter, applications of heat packs or cold packs can be used per the ODG. The ODG states that continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited but studies confirm that it may be a low risk low cost option. The ODG does discuss postoperative use of a hot/cold therapy unit in regards to shoulder and knee surgery but postoperative use may be up to 7 days including home use. The request for a hot/cold contrast therapy unit for purchase is not medically necessary. The documentation is not clear on why this would be necessary to be purchased rather than rented. Furthermore the guidelines do not recommend a contrast therapy unit for low back surgery. The request for a hot/cold contrast therapy unit for purchase is not medically necessary.

MUSCLE STIMULATOR PURCHASE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: Muscle stimulator purchase is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that neuromuscular electrical stimulation is not recommended and is primarily as part of a rehabilitation program following stroke with no evidence to support its use in chronic pain. The documentation does not indicate evidence of stroke or that this will be used in a rehabilitation program for stroke. The request for a muscle stimulator purchase is not medically necessary.