

Case Number:	CM14-0174608		
Date Assigned:	10/31/2014	Date of Injury:	02/16/2013
Decision Date:	12/15/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/21/2014

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 Orthopaedic 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 56-year-old female senior admissions representative sustained an industrial injury on 2/16/13. The mechanism of injury was described as a fall. The patient underwent an L5/S1 decompression on 7/25/14 and anterior lumbar discectomy and fusion from L4-S1 on 11/12/13. The 6/11/14 lumbar spine MRI revealed findings of instrumented lumbar fusion L4/5 and L5/S1 associated with interbody disc spacer grafts, trace anterolisthesis L4/5, and facet arthrosis with spinal stenosis L4/5. There was a left hemilaminectomy defect at L5/S1 with considerable epidural and perineural scarring along the left lateral thecal sac and around the emerging left S1 nerve root. A persistent 6 mm deep central disc herniation was also noted at L5/S1 without nerve root compression or central or foraminal stenosis. The 9/26/14 lower extremity electrodiagnostic study showed evidence of left S1 radiculopathy with both chronic and active denervation changes. The 9/29/14 treating physician report cited grade 8/10 low back pain with severe left lower extremity numbness, tingling, and burning. Physical exam documented 4/5 left S1 myotomal weakness and positive nerve tension signs on the left. She was unable to toe walk on the left. Authorization for left L5/S1 revision decompression and associated surgical requests was requested on 10/2/14 given the findings of nerve root compression. The 10/7/14 utilization review modified the 10/2/14 request and approved the requests for left L5/S1 revision decompression, outpatient surgery center, assistant surgeon, medical clearance and physical therapy 2x6. The requests for a hot/cold therapy unit and a muscle stimulator were denied as there was no justification and the treating physician agreed to the overall modification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/Cold Therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 160-161.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) guidelines state that the routine use of high-tech devices for hot or cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of hot or cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a cold/hot therapy unit in the absence of guideline support. Therefore, this request is not medically necessary.

Muscle stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) guidelines recommend the use of transcutaneous electrotherapy in the treatment of pain when specific indications are met for individual electrotherapy modalities. In general, muscle stimulation would suggest interferential current (IFC), neuromuscular electrical stimulation (NMES), and galvanic current. MTUS guidelines for transcutaneous electrotherapy do not recommend NMES for post-operative use. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that IFC is not recommended as an isolated intervention, and indications include failure to respond to conservative measures, including medications. Guideline criteria have not been met. As the specific electrotherapy and associated treatment goals have not been defined, the medical necessity of this request cannot be established. There is no evidence that this patient will fail to respond to surgical intervention and standard conservative pain treatment. Therefore, this request is not medically necessary.