

Case Number:	CM14-0175180		
Date Assigned:	10/28/2014	Date of Injury:	01/07/2009
Decision Date:	12/04/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/22/2014

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 Orthopedic Spine Surgeon and is licensed to practice in Texas. 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 injured worker is a 49-year-old female who reported an injury on 02/17/2009. The injured worker worked for the [REDACTED] as a law enforcement technician and secretary. Reportedly she sustained injuries to continuous trauma that included numbness and headaches, and cumulative trauma due to the usual and customary job duties. The injured worker's treatment history included magnetic resonance imaging (MRI) studies of the brain, and cervical spine, blood tests, Electromyography/Nerve Conduction Velocity (EMG/NCV) studies, and a CPAP machine for sleep apnea. The injured worker had undergone an MRI of the lumbar spine dated 10/10/2013 that revealed left paracentral disc protrusion at L3-4, with moderate narrowing of the cauda) margin of the left neural foramen and partial effacement of the left lateral recess. There as an annular tear along the caudal margin of the disc protrusion. There was a broad based right paracentral disc protrusion at L5-S1 with partial effacement of the right lateral recess. The injured worker was evaluated on 09/23/2014 and it was documented the injured worker complained of constant pain in the low back that was aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, prolonged standing, walking multiple blocks. The pain was characterized as sharp. There was radiation of pain into the lower extremities. The injured worker's pain was unchanged. The injured worker rated her pain on the pain scale at 8/10. Physical examination of the lumbar spine revealed palpable paravertebral muscle tenderness with spasm. Seated nerve root test was positive. Range of motion standing flexion, extension were guarded and restricted. There was no clinical evidence of instability on the examination. Injured states "circulations in the lower extremities were full." Sensation and strength there was tingling and numbness in the posterior leg and lateral foot which correlates with an L5-S1 dermatomal pattern. There was 4/5 strength in the ankle plantar flexors, and S1 innervated muscle. Ankle reflexes were asymmetric. Diagnoses included cervical

discopathy/cervicalgia, lumbar discopathy with radiculopathy, and electrodiagnostic evidence of chronic left L5 radiculopathy. The Request for Authorization was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Ice Unit for Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Shoulder (Acute & Chronic) Cold Compression Therapy

Decision rationale: The requested is not medically necessary. The Official Disability Guidelines (ODG) does not recommend ice therapy in the shoulder, as there are no published studies. It may be an option for other body parts. Game Ready device provides both active, continuous cold and intermittent, pneumatic compression to the post-op joint. There has been an RCT underway since 2008 to evaluate and compare clinical post-operative outcomes for patients using an active cooling and compression device (Game Ready), and those using ice bags and elastic wrap after acromioplasty or arthroscopic rotator cuff repair, but the results are not available. The documentation submitted for review was not clear if injured worker had completed surgery. In addition, the request failed to indicate location ice therapy unit is needed for the injured worker. The request for Ice Unit Purchase is not medically necessary.

Associated Surgical Service: Bone Stimulator for 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 - TWC Electrical 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 Problems Bone Growth Stimulator.

Decision rationale: The requested is not medically necessary. The Official Disability Guidelines (ODG) state that "bone growth stimulator is under study." There is conflicting evidence, so case by case recommendations are necessary (some RCTs with efficacy for high risk cases). Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases (e.g., revision pseudoarthrosis, instability, and smoker). There is no consistent medical evidence to support or refute use of these devices for improving patient outcomes; there may be a beneficial effect on fusion rates in patients at "high risk", but this has not been convincingly demonstrated. The documents submitted for review failed to indicate if the injured worker had any of the above criteria to warrant a purchase for a bone stimulator. In addition the request submitted for review failed to indicate where the bone stimulator is required for the

injured worker. Given the above, the request does not support the guidelines to warrant a purchase of a bone growth stimulator unit. Therefore, the request for a Bone Stimulator is not medically necessary.

Associated Surgical Service: 3-1 Commode for Purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee & Leg, Durable Medical Equipment.

Decision rationale: The requested is not medically necessary. According to the Official Disability Guidelines (ODG) state that "Durable medical equipment is for medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature." Certain DME toilet items (commodes, bed pans, etc.) are medically necessary if the patient is bed- or room-confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. The provider failed to indicate the rationale why he was requesting 3-1 commode for purchase for the injured worker. As such, the request for 3-1 commode for purchase is not medically necessary.