

Case Number:	CM14-0029409		
Date Assigned:	06/16/2014	Date of Injury:	03/30/2012
Decision Date:	07/17/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/07/2014

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 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 29-year-old male sustained an industrial injury 3/30/12. The mechanism of injury is not documented. He is status post lumbar laminectomy and discectomy at L5/S1 on the left. The 7/30/13 lumbar MRI impression documented L5/S1 left laminectomy and a left paracentral disc protrusion with left foraminal narrowing and bilateral facet hypertrophy. There was soft tissue adjacent to the left S1 nerve root, possibly disc material but granulation tissue could not be excluded. There were multilevel disc bulges from L1 to L5 with left foraminal narrowing at L4/5 and bilateral facet hypertrophy at L3/4 and L4/5. The 2/3/14 treating physician report cited subjective complaints of back and left leg pain with marked loss of lumbar flexion, mild loss of extension and rotation, and no new motor or sensory deficits. The patient underwent a microdiscectomy at L5/S1 on the left which did not help. The treating physician opined the medically necessary of revision surgery. The request for revision L5/S1 decompression and fusion was denied in utilization review. The 2/20/14 utilization review denied the requests for post-operative cold therapy, SurgiStim unit rental, back brace, and a 3-1 commode shower chair as the surgery had been denied. Records indicate that the requested revision surgery has not subsequently been approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST OPERATIVE COLD THERAPY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, 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) Low Back - Lumbar & Thoracic, Cold/heat packs.

Decision rationale: Under consideration is a request for a post-operative cold therapy unit. The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines recommend cold/heat packs as an option for acute low back pain. In general, guidelines recommend continuous flow cryotherapy systems for up to 7 days post-operative use. As the associated surgical procedure is not approved, this request for post-operative cold therapy is not medically necessary.

POST OPERATIVE SX STIM RENTAL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (Nmes Devices).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS).

Decision rationale: Under consideration is a request for post-operative SurgiStim rental. The SurgiStim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES or galvanic stimulation in the treatment of chronic pain. Guidelines suggest that interferential current is not recommended as an isolated intervention. Guidelines support limited use of TENS unit in the post-operative period. As the associated surgical procedure is not approved, this request for post-operative Sx Stim unit is not medically necessary.

POST OPERATIVE BONE BACK BRACE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 138-139.

Decision rationale: Under consideration is a request for a post-operative bone back brace. The California MTUS guidelines do not recommend the use of lumbar supports for prevention or treatment of lower back pain. However, guidelines state that lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. As the associated surgical procedure is not approved, this request for post-operative bone back brace is not medically necessary.

POST OPERATIVE 3-1 COMMUNE SHOWER CHAIR (PURCHASE): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, 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, Bathtub seats.

Decision rationale: Under consideration is a request for post-operative 3-1 commode shower chair. The California MTUS is silent regarding this durable medical equipment. The Official Disability Guidelines state that certain DME toilet items (commodes) are medically necessary if the patient is room-confined or when prescribed as part of a medical treatment plan for injury or conditions that result in physical limitations. As the associated surgical procedure is not approved, this request for 3-1 commode shower chair is not medically necessary.