

<b>Case Number:</b>	CM14-0037509		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	10/02/2008
<b>Decision Date:</b>	07/28/2014	<b>UR Denial Date:</b>	03/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/28/2014

### 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 Family Practice 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:

The patient is a 46-year-old female claimant, who sustained a work related injury on 10/2/08 involving the low back and sacroiliac joint. She has a diagnosis of spondylolisthesis and underwent a L5-S1 fusion. She had undergone joint injections with 80% relief. She had used Norco and Cymbalta for pain control. In addition, she had received epidural injections, chiropractic treatment and physical therapy. A progress note on 3/20/14 indicated the claimant had continued sacroiliac pain with only 3 days of relief with a sacroiliac injection. The treating physician recommended sacroiliac joint fusion and the use of a lumbosacral orthosis/ cold therapy along with a sacroiliac bone growth stimulator after surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable medical equipment (unspecified of purchase or rental) lumbosacral orthosis:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): table 2.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Pain.

**Decision rationale:** According to the ACOEM guidelines: Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The ODG states the following regarding lumbar braces: Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician. There is conflicting evidence, so case-by-case recommendations are necessary (few studies though lack of harm and standard of care). There is no scientific information on the benefit of bracing for improving fusion rates or clinical outcomes following instrumented lumbar fusion for degenerative disease. Although there is a lack of data on outcomes, there may be a tradition in spine surgery of using a brace post-fusion, but this tradition may be based on logic that antedated internal fixation, which now makes the use of a brace questionable. For long bone fractures, prolonged immobilization may result in debilitation and stiffness; if the same principles apply to uncomplicated spinal fusion with instrumentation, it may be that the immobilization is actually harmful. Mobilization after instrumented fusion is logically better for health of adjacent segments, and routine use of back braces is harmful to this principle. There may be special circumstances (multilevel cervical fusion, thoracolumbar unstable fusion, non-instrumented fusion, mid-lumbar fractures, etc.) in which some external immobilization might be desirable. (Resnick, 2005) Based on the above, the use of a lumbar support is not medically necessary.

**Bone stimulator for the left sacroiliac joint.:** 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 Official Disability Guidelines (ODG) Low Back Complaints.

**Decision rationale:** The ACEOM and MTUS guidelines do not comment on bone growth stimulators. According to the ODG guidelines: Bone Growth Stimulators: 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, smoker). (Mooney, 1990) (Marks, 2000) (Akai, 2002) (Simmons, 2004) 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. (Resnick, 2005) Also see Fusion for limited number of indications for spinal fusion surgery. See Knee & Leg Chapter for more information on use of Bone-growth stimulators for long bone fractures, where they are recommended for certain conditions. Criteria for use for invasive or non-invasive electrical bone growth stimulators: Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor); (5) Diabetes, Renal disease, Alcoholism; or (6)

Significant osteoporosis, which has been demonstrated on radiographs. (Kucharzyk, 1999) (Rogozinski, 1996) (Hodges, 2003) Based on the above, the use of Bone Stimulator is not medically necessary.

**Cold Therapy Unit:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** The ODG guidelines make the following statement regarding cold therapy: Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel. Based on the above, the Cold Therapy Unit is not medically necessary.