

Case Number:	CM14-0069518		
Date Assigned:	07/14/2014	Date of Injury:	01/15/2010
Decision Date:	09/16/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/14/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 52-year-old female who has submitted a claim for lumbar post laminectomy syndrome, medication induced gastritis, and removal of posterior fusion hardware L3, L4, and L5 with repair of pseudarthrosis (02/17/2014) associated with an industrial injury date of 01/15/2010. Medical records from 11/18/2013 to 06/19/2014 were reviewed and showed that patient complained of low back pain graded 7/10. Physical examinations revealed tenderness to palpation and trigger points over lumbar paraspinal muscles and increased muscle rigidity. Decreased lumbar range of motion (ROM) was noted. Patellar and ankle reflexes were 1+ bilaterally. Sensation to light touch was decreased along posterolateral thighs and calves bilaterally. Straight Leg Raise (SLR) test was positive bilaterally. Electromyography (EMG) of the lower extremities dated 03/19/2013 revealed chronic left L5 radiculopathy. MRI of the lumbar spine dated 04/23/2011 revealed L5-S1 disc protrusion and L3-4 and L4-5 facet joint hypertrophy. Treatment to date has included lumbar fusion L3-4 through L5-S1 (01/10/2012), removal of posterior fusion hardware L3,L4, and L5 with repair of pseudoarthrosis (02/17/2014), physical therapy, home exercise program, trigger point injections, activity modification, Norco, Anaprox, Fexmid, Prilosec, and Neurontin. Utilization review dated 04/22/2014 denied the request for "Thermacooler" system with pad and wrap because the medical necessity for the requested service cannot be determined at this time. Utilization review dated 04/22/2014 denied the request for Lumbar Sacral Orthosis (LSO) back support because the use of lumbar supports was under study for postoperative use and not recommended by the guidelines. Utilization review dated 04/22/2014 denied the request for Interferential Stimulation (IF)/Transcutaneous Electrical Nerve Stimulation (TENS) unit combo, electrodes, batteries, set up and delivery because there was no documentation suggesting that the patient will be participating in any type of functional restoration program at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

LSO back support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back, cold/heat packs.

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 Supports.

Decision rationale: CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines (ODG) was used instead. ODG states that lumbar support is not recommended for prevention of back pain. A systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. In this case, the patient complained of low back pain which prompted a request for Lumbar Sacral Orthosis (LSO) back support. However, the guidelines state that lumbar support is not recommended for prevention of back pain. It is unclear as to why variance from the guidelines is needed. Therefore, the request for LSO back support is not medically necessary.

IF/ TENS unit combo, electrodes, batteries, set up and delivery: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (chronic pain) Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS; Interferential Current Stimulation Page(s): 114-116; 118-120.

Decision rationale: According to CA MTUS Chronic Pain Treatment Guidelines, Transcutaneous Electrical Nerve Stimulation (TENS) is recommended as a treatment option for acute post-operative pain in the first 30 days post-surgery. TENS is not recommended as a primary treatment modality. A trial of one-month home-based TENS may be considered as a noninvasive conservative option. It should be used as an adjunct to a program of evidence-based functional restoration. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. The CA MTUS Chronic Pain Treatment Guidelines state that Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. In this case, the patient underwent removal of posterior fusion hardware L3,

L4, and L5 with repair of pseudoarthrosis on 02/17/2014. The patient's postoperative status has exceeded the guidelines recommendation of TENS use for the first 30 days post-surgery. Moreover, it is unclear if the patient is actively participating in functional restoration program. TENS and ICS are not recommended by the guidelines to be used as solitary form of treatment. Therefore, the request for Interferential Stimulation (IF)/TENS unit combo, electrodes, batteries, set up and delivery is not medically necessary.

Thermacooler system with pad/wrap: 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 Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Aetna Clinical Policy Bulletin was used instead. Aetna considers the use of the Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and failed to show that the Ice Machine offers any benefit over standard cryotherapy with ice bags/packs. In this case, the patient complained of low back pain which prompted the request for Thermacooler system with wrap/pad. However, the guidelines state that Ice Machine and similar devices do not provide additional benefit compared with standard cryotherapy. It is unclear as to why conventional ice pack application will not suffice in treatment. Therefore, the request for Thermacooler system with pad/wrap is not medically necessary.