

<b>Case Number:</b>	CM14-0202194		
<b>Date Assigned:</b>	12/12/2014	<b>Date of Injury:</b>	01/18/2012
<b>Decision Date:</b>	02/04/2015	<b>UR Denial Date:</b>	11/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2014

### 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 Preventive Medicine and is licensed to practice in Indiana. 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 employee is a 52 year old male with date of injury of 1/18/2012. A review of the medical records indicate that the patient is undergoing treatment for displacement of cervical intervertebral disc without myelopathy, brachial neuritis, cervicalgia. Subjective complaints include continued pain in the cervical spine with radiation to bilateral upper extremities. Objective findings include limited range of motion of the cervical spine with tenderness to palpation of the paraspinals; sensory and motor exam normal in upper extremities. Treatment has included epidural steroid injections, Tylenol #3, physical therapy, and facet blocks. The utilization review dated 11/28/2014 non-certified Cervical MP collar, Foam collar, Spinal bone growth stimulator, and a motorized cold unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for Cervical MP collar purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back, Cervical Collar

**Decision rationale:** MTUS is silent on this topic, but ODG states the following regarding cervical collars: "Not recommended after single-level anterior cervical fusion with plate. The use of a cervical brace does not improve the fusion rate or the clinical outcomes of patients undergoing single-level anterior cervical fusion with plating." This employee does not meet the guidelines for a cervical collar. Therefore, the request for a Cervical MP collar is not medically necessary.

**Retrospective request for Foam collar purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back, Cervical Collar

**Decision rationale:** MTUS is silent on this topic, but ODG states the following regarding foam collars: "Not recommended after single-level anterior cervical fusion with plate. The use of a cervical brace does not improve the fusion rate or the clinical outcomes of patients undergoing single-level anterior cervical fusion with plating." This employee does not meet the guidelines for a cervical collar. Therefore, the request for a foam collar is not medically necessary.

**Retrospective request for spinal growth stimulator 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 (ODG), Knee \* Leg (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lower Back, Bone Growth Stimulators

**Decision rationale:** MTUS is silent on this topic, but ODG states, "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." The medical documents do not indicate when the most recent trial of physical therapy sessions were utilized or what other less invasive treatments have been tried with the objective results of those treatments. Additionally, no quantifying of patient's pain level or functional level was present in progress notes, which is important to assess the level of pain typically experienced by the patient. As such, the request for a spinal growth stimulator is not medically necessary.

**Retrospective request for Motorized cold unit 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 (ODG), 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 and Thoracic), Lumbar Support and on Other Medical Treatment Guideline or Medical Evidence: <http://www.deroyal.com/medicalproducts/orthopedics/product.aspx?id=pc-temptherapy-coldtherunit>.

**Decision rationale:** MTUS is silent on the use of cold therapy units. ODG for heat/cold packs states "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) The use of devices that continually circulate a cooled solution via a refrigeration machine have not been shown to provide a significant benefit over ice packs. As such, the request for motorized cold therapy unit is not medically necessary.