MAXIMUS Federal Services

Case Number:	CM15-0133219		
Date Assigned:	07/21/2015	Date of Injury:	07/28/2013
Decision Date:	08/17/2015	UR Denial Date:	07/07/2015
Priority:	Standard	Application Received:	07/08/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Massachusetts
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 (IW) is a 45-year-old female who sustained an industrial injury on 07/28/2013. Diagnoses include L5-S1 herniated nucleus pulposus; L3-4 and L5-S1 spondylosis with disc bulge; and lumbar strain. No previous treatments were included in the documentation submitted and reviewed. According to the Spinal Consultation and Evaluation/Panel Qualified Medical Evaluation dated 12/11/14, the IW reported back pain rated 6/10 with bilateral leg weakness. Medications included Norco, Tramadol, Soma, Prilosec and Naproxen. On examination, range of motion of the lumbar spine was restricted; severe pain inhibition and muscle guarding was noted. There was pain to palpation of the lower lumbar spine. Neuro-motor evaluation was normal and equal bilaterally. Reflexes and sensation were intact. Straight leg raise was positive bilaterally with pain down to the heels. MRI of the lumbar spine on 8/28/14 found mild bilateral facet arthropathy at L5-S1; type 2 endplate change; marginal osseous ridging with mild bilateral foraminal stenosis; and minimal annular bulging at L3-4 without evidence of focal disc extrusion or neural compression. A request was made for hot/cold therapy unit; bone growth stimulator; and muscle stimulator (interferential stimulator, electrodes), rental for three months in relation to the authorized spinal surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Hot cold therapy unit: 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), Shoulder.

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 (Acute & Chronic), Cold/Heat packs.

Decision rationale: The claimant sustained a work-related injury in July 2013 and continues to be treated for low back pain. An anterior lumbar decompression and fusion at L5/S1 is being planned. When seen, there was a negative past medical history. The claimant is a non-smoker and drinks alcohol occasionally. There was decreased lumbar range of motion with muscle guarding and tenderness. Straight leg raising was positive and there was an antalgic gait. Use of heat and ice are low cost as at-home applications, has few side effects, and are noninvasive. The at-home application of heat or cold packs is recommended. However, in this case, simple, low-tech thermal modalities would meet the claimant's needs. A combination hot/cold unit is not needed for this claimant's post-operative treatment. Therefore, the request is not medically necessary.

Associated surgical service: Bone growth stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back.

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 (Acute & Chronic), Bone growth stimulators (BGS).

Decision rationale: The claimant sustained a work-related injury in July 2013 and continues to be treated for low back pain. An anterior lumbar decompression and fusion at L5/S1 is being planned. When seen, there was a negative past medical history. The claimant is a non-smoker and drinks alcohol occasionally. There was decreased lumbar range of motion with muscle guarding and tenderness. Straight leg raising was positive and there was an antalgic gait. In terms of a bone growth stimulator, case-by-case recommendations are necessary. A bone stimulator 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; (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. In this case, none of these risk factors is present. The requested bone stimulator is not medically necessary.

Associated surgical service: Muscle stimulator (Interential stimulator, electrodes) rental for 3 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulations (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Page(s): 114-121.

Decision rationale: The claimant sustained a work-related injury in July 2013 and continues to be treated for low back pain. An anterior lumbar decompression and fusion at L5/S1 is being planned. When seen, there was a negative past medical history. The claimant is a non-smoker and drinks alcohol occasionally. There was decreased lumbar range of motion with muscle guarding and tenderness. Straight leg raising was positive and there was an antalgic gait. A one-month trial of use of an interferential stimulator is an option when conservative treatments fail to control pain adequately. Criteria for continued use of an interferential stimulation unit include evidence of increased functional improvement, less reported pain and evidence of medication reduction during a one-month trial. If there was benefit, then purchase of a unit would be considered. In this case, there is no evidence of a failure of conservative treatments. Rental of a unit for 3 months would not be cost effective and not necessary to determine its efficacy. The requested unit is not medically necessary.