

Case Number:	CM15-0193179		
Date Assigned:	10/13/2015	Date of Injury:	07/05/2011
Decision Date:	12/18/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	10/01/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 is a 70 year old male, who sustained an industrial injury on 7-5-11. The injured worker was diagnosed as having lumbar spinal stenosis. Treatment to date has included chiropractic therapy; physical therapy; status post L4-S1 decompression - fusion with allograft and instrumentation (8-27-15); medications. Diagnostics studies included X-rays lumbar spine (10-7-15); Ultrasound Lower extremities (9-9-15). Currently, the PR-2 notes dated 7-10-15 indicated the injured worker presents as a follow-up visit. The provider documents "I last evaluated him five weeks ago at which time I recommended C5-C7 anterior cervical discectomy and fusion. I am still awaiting authorization for this procedure. The patient was also previously recommended to have a lumbar spine surgery and this was recently denied by independent medical review. The patient returns to me today with no changes in his symptoms. He is still complaining of low back pain radiating into the left leg as well as neck pain radiating into the left arm." The provider documents a physical examination on the lumbar spine stating: "There is tenderness to palpation over the paraspinal musculature. Inspection reveals normal lordosis. Flexion is 60 over 60 degrees and extension is 25 over 25 degrees. Right bend is 25 over 25 degrees and left bend is 25 over 25 degrees. There is no tenderness to palpation over the spinous processes. Sensation is diminished over the left L5 dermatome. There are 2 reflexes in the patellae and Achilles. Negative Achilles clonus and negative straight leg raising." The provider's treatment plan re-requested the injured worker's lumbar surgery. The injured worker is now a status post L4-S1 decompression-fusion with allograft and instrumentation that took place on 8-27-15. The provider is requesting associated services to be authorized at this time. A Request for

Authorization is dated 10-1-15. A Utilization Review letter is dated 8-31-15 and non-certification for IPC DVT therapy device, 1 month rental ; Bilateral pressure pneumatic appl purchase; Cooling system, purchase; Cooling system pad/wrap, purchase; LSO back support, purchase and Bone growth stimulator, purchase and set up and delivery. A request for authorization has been received for IPC DVT therapy device, 1 month rental ; Bilateral pressure pneumatic appl purchase; Cooling system, purchase; Cooling system pad/wrap, purchase; LSO back support, purchase and Bone growth stimulator, purchase and set up and delivery.

IMR ISSUES, DECISIONS AND RATIONALES

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

IPC DVT therapy device, 1 month rental: Overturned

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

http://www.spine.org/Documents/ResearchClinicalCare/Guidelines/Antithrombotic_therapies.pdf.

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 / Compression garment.

Decision rationale: The MTUS did not address the issue of DVT prophylaxis therefore other guidelines were consulted. Per the ODG, DVT prophylaxis is recommended. "Good evidence for the use of compression is available, but little is known about dosimetry in compression, for how long and at what level compression should be applied. Low levels of compression 10-30 mmHg applied by stockings are effective in the management of telangiectases after sclerotherapy, varicose veins in pregnancy, the prevention of edema and deep vein thrombosis (DVT). High levels of compression produced by bandaging and strong compression stockings (30-40 mmHg) are effective at healing leg ulcers and preventing progression of post-thrombotic syndrome as well as in the management of lymphedema. Prophylactic management of DVT is appropriate in this injured worker; therefore the request for IPC DVT therapy device, 1 month rental is medically necessary.

Bilateral pressure pneumatic appl purchase: Overturned

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

http://www.spine.org/Documents/ResearchClinicalCare/Guidelines/Antithrombotic_therapies.pdf.

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 / Compression garment.

Decision rationale: The MTUS did not address the issue of DVT prophylaxis therefore other guidelines were consulted. Per the ODG, DVT prophylaxis is recommended. "Good evidence for the use of compression is available, but little is known about dosimetry in compression, for how long and at what level compression should be applied. Low levels of compression 10-30 mmHg applied by stockings are effective in the management of telangiectases after sclerotherapy, varicose veins in pregnancy, the prevention of edema and deep vein thrombosis (DVT). High levels of compression produced by bandaging and strong compression stockings (30-40 mmHg) are effective at healing leg ulcers and preventing progression of post-thrombotic syndrome as well as in the management of lymphedema. Prophylactic management of DVT is appropriate in this injured worker, the request for IPC DVT therapy device, 1 month rental is medically necessary, therefore the request for bilateral pressure pneumatic appl purchase is medically necessary.

Cooling system, purchase: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, 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 / Continuous Flow Cryotherapy.

Decision rationale: The MTUS did not address the use of Cooling systems therefore other guidelines were consulted. Per the ODG, "recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. (Hubbard, 2004) (Morsi, 2002) (Barber, 2000) The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting. (BlueCross BlueShield, 2005) This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of knee surgery. (Raynor, 2005) There is limited information to support active vs passive cryo units. Aetna considers passive hot and cold therapy medically necessary. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. (Aetna, 2006) This study concluded that continuous cold therapy devices, compared to simple icing, resulted in much better nighttime pain control and improved quality of life in the early period following routine knee arthroscopy. the use of a cooling system in the post operative setting would aid in healing in this injured worker who is of advanced age, therefore the request for Cooling system, purchase is medically necessary.

Cooling system pad/wrap, purchase: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, 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 / Continuous flow cryotherapy.

Decision rationale: The MTUS did not address the use of Cooling systems therefore other guidelines were consulted. Per the ODG, "recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. (Hubbard, 2004) (Morsi, 2002) (Barber, 2000) The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting. (BlueCross BlueShield, 2005) This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of knee surgery. (Raynor, 2005) There is limited information to support active vs passive cryo units. Aetna considers passive hot and cold therapy medically necessary. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. (Aetna, 2006) This study concluded that continuous cold therapy devices, compared to simple icing, resulted in much better nighttime pain control and improved quality of life in the early period following routine knee arthroscopy. the use of a cooling system in the post operative setting would aid in healing in this injured worker who is of advanced age, therefore the request for Cooling system, pad / wrap purchase is medically necessary.

LSO back support, purchase: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back: Back brace, post operative (fusion).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Back brace / Back brace, post operative (fusion).

Decision rationale: The MTUS did not address the use of post operative bracing therefore other guidelines were consulted. Per the ODG it is "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. 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, In this injured worker given his age the use of a back brace post operatively would be beneficial, therefore the request for LSO back support, purchase is medically necessary.

Bone growth stimulator, purchase and set up and delivery: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Bone Growth Stimulators.

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 / Bone Growth Stimulators (BGS).

Decision rationale: The MTUS did not address the use of bone growth stimulators, therefore other guidelines were consulted. Per the ODG, it is 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. 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) this injured worker is high risk due to his advanced age, the use of Bone growth stimulator, purchase, set up and delivery is appropriate and medically necessary.