

Case Number:	CM15-0198943		
Date Assigned:	10/14/2015	Date of Injury:	01/24/2012
Decision Date:	11/24/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/09/2015

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: Florida

Certification(s)/Specialty: Family Practice

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 43 year old man sustained an industrial injury on 1-24-2012. Evaluations include lumbar MRI dated 7-3-2014. Diagnoses include lumbosacral disc herniation, lumbosacral facet arthropathy, lumbosacral disc deterioration with end plate destruction ad grade II modic changes, and high grade foraminal stenosis bilaterally. Treatment has included oral medications. Physician notes dated 8-20-2015 show a pre-operative evaluation with complaints of low back pain. The physical examination shows a limp toward the right leg. Lumbar range of motion is noted to be extension 20 degrees, flexion 45 degrees, rotation 45 degrees, bilateral lower extremity strength is noted to be normal, sensation is diminished to light touch in the S1 dermatomal distribution, reflexes are trace throughout, and straight leg raise is positive to 30 degrees in the right leg. Recommendations include approval for surgical intervention. A handwritten order dated 9-14-2015 requests front wheeled walker, lumbosacral orthotic chair back brace, cold therapy unit, CTU pad, shower chair, 3 in 1 commode, and a bone stimulator machine for purchase. Utilization Review denied requests for spinal bone stimulator, cold therapy unit, and CTU pad on 9-28-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal bone stimulator, purchase, lumbar & sacral: 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), Lumbar Chapter, Bone growth stimulators (BGS), Knee and Leg Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Online 2015. Lumbar chapter: Bone Growth Stimulators/Criteria for Bone Growth Stimulators.

Decision rationale: MTUS guidelines does not address this request, and therefore other professional alternative sources were referenced. It is noted in several professional resources that Bone Growth Stimulators are under study. The ODG provides the following criteria for when such a stimulator should be considered. 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. Regarding this patient's case, the spinal surgery will only take place at one level. This case does not meet ODG criteria. Likewise, this request is not considered medically necessary.

Cold therapy unit purchase, lumbar and sacral: 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), Low Back Chapter-Cold/heat packs, heat therapy.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care.

Decision rationale: MTUS guidelines state regarding the use of ice/cold packs in the treatment of back and neck pain, "At-home local applications of cold packs during first few days of acute complaints; thereafter, applications of heat packs." In this patient's case a cold therapy unit is being requested. There is no literature recognized by the leading authorities in the medical community to support the use of a cold unit device over that of an at home ice pack application. Likewise, this request is not considered medically necessary.

CTU pad purchase, lumbar and sacral: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation BlueCross Blue Shield, DME, cooling devices used in home setting.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care.

Decision rationale: The cold therapy unit has been determined to not be medically necessary. Again, there is no literature recognized by the leading authorities in the medical community to support the use of a cold unit device over that of an at home ice pack application. Therefore, the CTU pad purchase for the cold therapy device is also not considered medically necessary.