

Case Number:	CM15-0020619		
Date Assigned:	02/10/2015	Date of Injury:	02/14/2011
Decision Date:	04/15/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	02/04/2015

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: Minnesota, Florida
 Certification(s)/Specialty: Orthopedic Surgery

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 58 year old female, who sustained an industrial injury on 2/14/2011. She has reported back and neck pain. The diagnoses have included lumbosacral disc degeneration, chronic low back pain, cervical disc injury status post cervical discectomy and fusion 2013, and chronic neck pain. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), chiropractic therapy, physical therapy, and analgesics. Currently, the IW complains of back pain rated 9/10 without medication and 7/10 with medication documented as becoming worse. Physical examination from 12/20/14 documented numbness and weakness on right side L5 and S1, straight leg raise positive, muscle spasms. Lumbar Range of Motion (ROM) decreases 80%. The plan of care included continuation of medication therapy and surgical intervention to include lumbar fusion. On 1/28/2015 Utilization Review non-certified post-operative hot/cold therapy unit purchase, bone growth stimulator, and retrospective QW full panel drug screen. The Utilization Review on 1/28/2015 modified certification for a muscle stimulator, to allow for Transcutaneous Electrical Nerve Stimulation (TENS) unit x 1 month rental. The MTUS, ACOEM, and ODG Guidelines were cited. On 2/4/2015, the injured worker submitted an application for IMR for review of post-operative hot/cold therapy unit purchase, bone growth stimulator, muscle stimulator, and retrospective QW full panel drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative hot/cold therapy unit for purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Low Back, Topic: Hot/cold therapy.

Decision rationale: ODG guidelines recommend Cold/Heat packs as an option for acute low back pain but not for postoperative use. Continuous-flow cryotherapy is used postoperatively for knee surgery and shoulder surgery but the use after a lumbar fusion has not been recommended. The evidence for application of cold treatment to low back pain is more limited than heat therapy. Evidence-based guidelines do not recommend continuous-flow cryotherapy or heat packs after low back surgery. As such, the request for purchase of the cold/heat therapy unit is not supported and the medical necessity of the request has not been substantiated.

Post-operative bone growth stimulator for 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), Lumbar Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Low Back, Topic: Bone growth stimulator.

Decision rationale: According to ODG guidelines, the indications for a bone growth stimulator after a lumbar fusion include a history of smoking, failure of a previous fusion, multiple level fusions, grade 3 spondylolisthesis, diabetes, renal disease, alcoholism, or significant osteoporosis which has been demonstrated on radiographs. The documentation provided does not indicate the presence of these risk factors. As such, the request for a bone growth stimulator is not supported and the medical necessity of the request has not been substantiated.

Post-operative muscle stimulator for purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation Page(s): 121.

Decision rationale: Neuromuscular electrical stimulation devices are not recommended for chronic pain. California MTUS chronic pain medical treatment guidelines indicate that these devices are used primarily as part of a rehabilitation program following a stroke. Unlike the TENS unit these devices do not alter the perception of pain. The documentation indicates a TENS unit trial has been certified. The postoperative use of the neuromuscular electrical

stimulation device is not supported by guidelines and as such, the medical necessity of the request for purchase of this device has not been substantiated.

QW full panel drug screen, performed on January 16, 2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Pain treatment agreement Page(s): 89.

Decision rationale: The guidelines recommend frequent random urine toxicology screens to avoid misuse of opioids in particular for those at high risk of abuse. The documentation indicates that the urine toxicology screens had been negative for opioids although the injured worker was supposedly taking opioids at that time. The provider was not overly concerned and there was no discussion with the injured worker documented with regard to the negative urine toxicology testing. The guidelines indicate that as part of an opioid pain treatment agreement, treatment compliance must occur and urine drug screens may be required. As such, repeat testing without a discussion of the previous results suggestive of noncompliance was not medically necessary. In light of the foregoing, the retroactive request for urine toxicology testing performed on January 16, 2015 is not supported and the medical necessity is not established.