

Case Number:	CM15-0087201		
Date Assigned:	05/11/2015	Date of Injury:	10/19/2011
Decision Date:	06/22/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/06/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 45-year-old male, who sustained an industrial injury on 10/19/2011. Diagnoses include chronic failed back syndrome, chronic lumbosacral radiculopathy and status post lumbar spine fusion. Treatment to date has included diagnostics and medications. Per the Primary Treating Physician's Progress Report dated 3/18/2015, the injured worker reported chronic pain with radiation to the bilateral lower extremities rated as 5/10. Physical examination revealed spasm and tenderness in the paravertebral muscles of the lumbar spine with decreased range of motion on flexion and extension. The plan of care included medications and an anesthetic block. Authorization was requested for a bone stimulator, brace and cryotherapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bone Stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Bone-growth stimulators (BGS), page 572: Under study.

Decision rationale: The patient had recent CT scan of lumbar spine on 3/3/15 showing multilevel laminectomy at L3-S1, stable fusion at L3-4, hardware removal with intact fusion graft at L4-S1 with seroma/lymphocele. There was mention for residual screw at L4. The provider noted patient with continued symptom complaints with plan for multilevel fusion. Utilization reviewer noted surgical request has not been authorized. Additionally, Guidelines note 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. Submitted reports have not demonstrated clinical findings to meet the criteria for the bone growth stimulator. Therefore, the request is not medically necessary and appropriate.

CyberTech Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: Submitted reports have not demonstrated indication of post-op complications, instability, compression fracture, or spondylolisthesis precautions to warrant a back brace for post-surgical back care. Reports have not adequately demonstrated the medical indication for the back brace. Based on the information provided and the peer-reviewed, nationally recognized guidelines, the request for a back brace cannot be medically recommended. CA MTUS states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. In addition, ODG states that lumbar orthosis are under study due to a lack of evidence and scientific information on the benefit of bracing for improving fusion rates or clinical outcomes following instrumented lumbar fusion for degenerative disease. It can be conferred that prolonged immobilization may result in debilitation and stiffness in long bone fractures and if the same principles apply to uncomplicated spinal fusion with instrumentation, it may be that the immobilization is actually harmful. Mobilization after instrumented fusion is recommended for health of adjacent segments except in special circumstance of multilevel cervical fusion, thoracolumbar unstable fusion, non-instrumented fusion, and mid-lumbar fractures, in which some external immobilization might be desirable; however, has not been demonstrated in this case with criteria not met and the patient has not been approved for surgery requested. Therefore, the request is not medically necessary and appropriate.

Cryotherapy (3-5 times a day for 1-month): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, pages 381-382.

Decision rationale: Guidelines state cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The request for authorization does not provide supporting documentation beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines. The request for the unit does not meet the requirements for medical necessity. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post surgery; however, limits the use for 7-day post-operative period, as efficacy has not been proven after. Therefore, the request is not medically necessary and appropriate.