

<b>Case Number:</b>	CM15-0088954		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	03/19/2013
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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: Illinois, California, Texas

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 41-year-old male who sustained an industrial injury on 3/19/13. Injury occurred when he was installing equipment and lifted the equipment overhead and felt a pop in his lower back. The 5/12/14 lumbar spine MRI documented an L4/5 broad-based right paracentral and posterolateral disc herniation with slight caudal migration, compression of the right thecal sac, and mild compression of the right L5 nerve root. There was mild central stenosis. At L5/S1, there was a small broad-based left paracentral and posterolateral disc protrusion with mild posterior displacement of the left S1 nerve root. The 4/22/14 treating physician report cited grade 8/10 low back pain radiating down both legs with numbness and tingling. Physical exam documented absent Achilles reflexes, decreased L5 and S1 dermatomal sensation bilaterally, and 4/5 weakness over the L5 and S1 myotomes. There was a positive straight leg raise, more than 50% loss of lumbar range of motion, and a marked list. A request for authorization was submitted for ALDF with allograft and cage plate of L4-5 and L5-S1, 3 day inpatient stay, assistant surgeon, medical clearance, hot/cold therapy unit, bone growth stimulator, muscle stimulator for muscle reeducation, LSO back brace and post-op physical therapy 12 sessions. Records documented 5 mm of motion with flexion/extension at L4/5 where there is retrolisthesis, and collapse of the disc space at L5/S1. The 4/30/15 utilization review certified a request for anterior lumbar decompression and instrumented fusion at L4/5 and L5/S1 with allograft bone, interbody cage, and anterior lumbar plating, co-surgeon, medical clearance, lumbar support, and 3 day inpatient stay. The requests for hot/cold therapy unit and muscle stimulator were non-certified as medical necessity was not established.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**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 [www.aetna.com/cpb/medical/data/200\\_299/0297.html](http://www.aetna.com/cpb/medical/data/200_299/0297.html).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

**Decision rationale:** The California MTUS are silent regarding hot/cold therapy devices, but recommend at home applications of hot or cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for hot or cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of hot or cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a hot/cold therapy unit in the absence of guideline support and over standard hot/cold packs. Therefore, this request is not medically necessary.

**Muscle stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

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

**Decision rationale:** The California MTUS guidelines do not support the use of a post-operative muscle stimulator. Guidelines for transcutaneous electrotherapy support the use of NMES in rehabilitating upper extremity muscles following stroke, as part of a comprehensive physical therapy program. Galvanic stimulation is considered investigational for all indications. Guideline criteria have not been met. This device was prescribed for muscle reeducation in the post-operative period. There is no compelling reason relative to documented muscle atrophy or inability to participate in physical therapy rehab to support the medical necessity of a muscle stimulator. Therefore, this request is not medically necessary.