

Case Number:	CM14-0145508		
Date Assigned:	09/12/2014	Date of Injury:	11/19/1996
Decision Date:	11/26/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/08/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a 46-year-old female who reported an industrial injury on 11/19/1996, 18 years ago, attributed to the performance of her usual and customary job duties. The patient is noted to be s/p lumbar laminectomy and fusion for L5 to S1. The request was made retrospectively for the purchase of a Chairback brace subsequent to the operative procedure dated 3/6/2014. The patient was reported to have had an L5-S1 stenosis secondary to disk herniation, grade III spondylolisthesis, and a pars defect with hypertrophied ligamentum. The patient failed conservative care and was recommended to undergo surgical intervention with a L5-S1 laminectomy with bilateral medial facetectomy and foraminotomies, L5-S1 transforaminal interbody fusion, L5-S1 posterior lateral fusion, and L5-S1 posterior instrumentation. The treatment request was a retrospective purchase of the Chairback brace for the date of surgery 3/6/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chairback Brace purchased on 3/06/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) back chapter-lumbar supports; back brace postoperative

Decision rationale: The patient was requested a Chairback brace (L0637) for the postoperative care of the lower back s/p lumbar spine fusion L5-S1. The medical necessity of the purchase of a Chairback brace postoperatively is under study. There is no evidence that there is functional benefit from bracing for improved fusion rates or clinical outcomes following instrumented lumbar fusion for degenerative disease. The patient was noted to have undergone posterior instrumentation with insertion of the cage. It is not clear that the requested Chairback brace is a matter of tradition of prescribing a postoperative back brace versus medically necessary to mean stability of the postoperative lumbar spine even with the addition of instrumentation. There was no rationale supported by objective evidence to support the medical necessity of the prescribed Chairback brace postoperatively for this patient after undergoing a single level lumbar spine fusion. The prescribed lumbar support was not demonstrated to be medically necessary or reasonable for the treatment of the effects of the industrial injury. There was no subjective/objective clinical evidence provided that demonstrated the medical necessity for the prescribed back brace for the treatment of the lower back s/p lumbar spine fusion with instrumentation. The current evidence based guideline treatment recommendations favor active rehabilitation and exercise over the use of lumbar supports/corsets. Therefore, Chairback Brace purchased on 3/06/14 is not medically necessary and appropriate.

Motorized Cold Therapy Unit purchased on 3/06/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 300, 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg chapter cold heat packs; continuous flow cryotherapy; Low back chapter cold/head packs

Decision rationale: The use of the cold circulation units are recommended by evidence-based guidelines for hospital use but not for home use. There is no demonstrated medical necessity for this cold therapy unit with appliance to be provided to the patient subsequent to the surgical intervention to the lumbar spine for home treatment as opposed to the conventional treatment with cold packs. The medical necessity of the DME for the home treatment of the patient was not supported with objective evidence to support medical necessity. There is no objective evidence to support the home use of the requested cold therapy system as opposed to the customary RICE for the treatment of pain and inflammation after the initially recommended seven (7) days of home therapy with a cold therapy unit. There was no clinical documentation provided to support the medical necessity of the requested DME in excess of the recommendations of the California MTUS. The use of a cold circulation pump post operatively is recommended for up to seven (7) days and not recommended for longer durations of time. There is no demonstrated medical necessity for the purchase of a cold circulation unit for the treatment of the lumbar spine status post L5-S1 fusion. The cold therapy units are not medically necessary for the treatment of the

lumbar spine post-operatively as alternatives for the delivery of heat and cold to the back are readily available. The request for authorization of the cold therapy by name brand is not supported with objective medically based evidence to support medical necessity. There is no provided objective evidence to support the medical necessity of the requested cold unit as opposed to the more conventional methods for the delivery of cold for the cited surgical intervention rehabilitation. The CA MTUS; the ACOEM Guidelines and the ODG recommend hot or cold packs for the application of therapeutic cold or heat. The use of hot or cold is not generally considered body part specific. The Official Disability Guidelines chapter on the knee and lower back states a good example of general use for hot or cold. The issue related to the request for authorization is whether an elaborate mechanical compression device is necessary as opposed to the recommended hot or cold pack. Therefore, the Motorized Cold Therapy Unit purchased on 3/06/14 is not medically necessary and appropriate.