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| Case Number: | CM14-0155430 | | |
| Date Assigned: | 09/25/2014 | Date of Injury: | 05/31/2008 |
| Decision Date: | 06/30/2015 | UR Denial Date: | 09/05/2014 |
| Priority: | Standard | Application Received: | 09/23/2014 |

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. 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 54-year-old male who sustained an industrial injury on 5/31/08. Injury occurred relative to carrying cement up and down a 24-foot ladder with onset of low back and right shoulder pain. Past medical history was positive for diabetes. The 11/14/11 lower extremity electrodiagnostic study was reported as normal. The 11/17/11 lumbar spine MRI impression documented disc degeneration and narrowing in the lower lumbar spine. At L5/S1, there was decreased disc signal and disc height with 1 cm tear present extending posteromedially into the annulus. There was a 4 mm broad-based posterior disc protrusion indenting the thecal sac, right greater than left, with moderate central canal stenosis and mildly stenotic foramina. At L3/4, there was mildly decreased disc space height and signal, and a 1-2 mm disc bulge indenting the thecal sac with slightly reduced central canal. Conservative treatment was reported to include physical therapy, hot and cold therapy, acupuncture, anti-inflammatory medications, and activity modification. The 8/18/14 treating physician report cited grade 6/10 right shoulder pain, grade 9/10 back pain, and grade 8/10 right leg pain and tingling. Physical exam documented positive straight leg raise, decreased range of motion, and decreased L5 sensation and motor on the right. The treatment plan recommended back surgery. The 9/5/14 utilization review non-certified the requests for cold therapy unit, back brace, bone stimulator and 3-in-1 commode shower chair as the associated lumbar fusion was not medically necessary. There was no evidence in the submitted records relative to the specific surgery being requested or that it was found medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Unit 7 days Rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Cold/heat packs.

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 cold therapy devices, but recommend at home applications of cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of 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 cold therapy unit in the absence of guideline support. Therefore, this request is not medically necessary.

Back Brace 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, Low Back, Back brace, post operative (fusion).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138-139.

Decision rationale: The California MTUS guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The revised ACOEM Low Back Disorder guidelines do not recommend the use of lumbar supports for prevention or treatment of lower back pain. However, guidelines state that lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. Although the use of a lumbar support may be reasonable in the post-operative period, there is no evidence that back surgery has been found medically necessary. Therefore, this request is not medically necessary.

Bone 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, Low Back, Bone growth stimulators (BGS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic Bone growth stimulators (BGS).

Decision rationale: The California MTUS guidelines are silent regarding bone growth stimulators. The Official Disability Guidelines indicate that bone growth stimulators are under study and may be considered medically necessary as an adjunct to lumbar 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; (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. This request would be supported for a lumbar fusion based on the comorbidity of diabetes. However, there is no current documentation relative to the type of back surgery being requested or that the surgery has been found medically necessary. Therefore, this request is not medically necessary.

3-1 Commode Shower Chair 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, Knee & Leg, Durable medical Equipment (DME).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Durable medical equipment (DME).

Decision rationale: The California MTUS is silent regarding this durable medical equipment. The Official Disability Guidelines state that certain DME toilet items (commodes) are medically necessary if the patient is room-confined or when prescribed as part of a medical treatment plan for injury or conditions that result in physical limitations. The use of a 3-in-1 commode following lumbar fusion would be reasonable for expected physical limitations and to allow for early functional independence. However, there is no current documentation relative to the type of back surgery being requested or that the surgery has been found medically necessary. Therefore, this request is not medically necessary.