

Case Number:	CM13-0020933		
Date Assigned:	03/26/2014	Date of Injury:	06/26/2012
Decision Date:	05/21/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/06/2013

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 Orthopedic Surgery 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 58-year-old gentleman sustained an injury to his low back while pushing a rack on 06/26/12. A clinical progress report of 02/10/14 indicated that the claimant is status post a prior L3 through L5 anterior lumbar discectomy and fusion performed 10/01/13. It documented that he is with continued instability at L3-4 and L4-5 with stenosis and a chronic myoligamentous strain. He continues to treat with medication management and there are postoperative radiographs of 01/13/14 which were documented as stable. He was with a normal gait pattern. Normal motor, sensory, and reflex examinations and negative straight leg raising. There is no documentation of any other postoperative imaging. Preoperative imaging is also not available for review. At present, there is a request for authorization to proceed with a revision fusion procedure at L3-4 and L4-5 with radiological evaluation, postoperative use of a heat and cold therapy unit and interferential muscle stimulator with conductive garment and "refill medications."

IMR ISSUES, DECISIONS AND RATIONALES

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

REVISION OF FUSION AT L3-4 AND L4-5: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

Decision rationale: Based on California MTUS ACOEM Guidelines, the requested revision fusion procedure would not be indicated. Records indicate that he is stable on postoperative imaging and the examination findings were negative for any evidence of neurologic deficit. There is not any clinical indication for a revision fusion procedure given the claimant's current stable clinical presentation.

RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; BENDING VIEWS ONLY, 2 OR 3 VIEWS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 11th Edition, 2013, Low Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: California MTUS ACOEM Guidelines indicate that imaging should be reserved for cases in which there is the potential for surgery and or in cases where there are red flag indicators. When looking at Official Disability Guidelines criteria, lumbar radiographs also would not be indicated as there is not a medical necessity for the requested surgical procedure and no red flag indicators documented.

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 Official Disability Guidelines, 11th Edition, 2013, Knee, Continuous Flow Cryotherapy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

Decision rationale: The California MTUS Guidelines are silent and Official Disability Guidelines indicate that home application of heat/cold is appropriate and that there is no evidence that would support that heat/cold should be applied by a therapist. When looking at Guideline criteria, the requested heat and cold therapy unit in the postoperative setting would not be indicated as the revision fusion procedure is not medically.

MEDS INF MUSCLE STIMULATOR WITH CONDUCTIVE GARMENT: 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 Interferential Current Stimulation (ICS) Page(s): 118.

Decision rationale: The California MTUS Guidelines would not support the role of interferential muscle stimulator or garment device as the need for operative intervention in this case has not been established.

REFILL OF MEDICATIONS: 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 Functional Restoration Approach To Chronic Pain Management Page(s): 8-9.

Decision rationale: The vague request for "refill medications" would not be considered as medically necessary as there is no clinical indication as to the specific medications that are to be refilled. "As stated on page 47 of the ACOEM Practice Guidelines, "consideration of comorbid conditions, side effects, cost, and efficacy of medication versus physical methods and provider and patient preferences should guide the physician's choice of recommendations." Absent the aforementioned information the request for refill of medications cannot be recommended as medically necessary.