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| <b>Case Number:</b>   | CM14-0013431 |                              |            |
| <b>Date Assigned:</b> | 02/26/2014   | <b>Date of Injury:</b>       | 03/27/2009 |
| <b>Decision Date:</b> | 06/27/2014   | <b>UR Denial Date:</b>       | 01/22/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/03/2014 |

### 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 Orthopedic Surgery, and is licensed to practice in Pennsylvania. 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:

The claimant is a 55-year-old female injured in a March 27, 2009, work-related accident. The records provided for review document an injury to the low back, for which surgery for an L3-S1 anterior and posterior interbody fusion with instrumentation was recommended and then performed on February 5, 2014. This review request is for perioperative services, including: a 10- to 14-day inpatient hospital stay; a two-week outpatient rehabilitation admission; purchase of a front-wheeled walker; purchase of a cryotherapy unit; and purchase of a pneumatic intermittent compression device. The available clinical records do not reference information pertinent to this series of requests.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **TEN TO FOURTEEN DAY HOSPITAL STAY: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: low back procedure - Fusion (spinal)- Hospital length of stay (LOS)

**Decision rationale:** California MTUS and ACOEM Guidelines do not provide criteria relevant to this request. According to Official Disability Guidelines, a 10- to 14-day hospital stay cannot be supported in this case. The Official Disability Guidelines recommend up to a three-day length of inpatient stay following lumbar fusion. There is no documentation in the records provided for review that would indicate that the claimant is an exception to standard treatment or experienced a complication following surgery that would require additional inpatient days. The request for a 10- to 14-day stay exceeds ODG Guidelines criteria and would not be indicated as medically necessary.

**TWO WEEKS OF ACUTE POST OP REHAB ADMISSION:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: knee procedure - Skilled nursing facility LOS (SNF)

**Decision rationale:** California MTUS ACOEM Guidelines do not provide criteria relevant to this request. According to Official Disability Guidelines, a two-week skilled nursing facility admission would be supported in this case. The ODG Guidelines recommend a 10- to 18-day length of stay in a skilled nursing facility following aggressive procedures, including spinal surgeries, for rehabilitative purposes. This request for a two-week, subacute rehabilitation admission falls within the guidelines range and, therefore, would be indicated as medically reasonable.

**PURCHASE OF FRONT WHEEL WALKER:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: knee procedure - Walking aids (canes, crutches, braces, orthoses, & walkers)

**Decision rationale:** California MTUS and ACOEM Guidelines do not provide criteria relevant to this request. According to Official Disability Guidelines, a front-wheeled walker would be supported in this case. Given the nature of the claimant's multilevel fusion procedure, the role of a walker for stabilization purposes in the post-operative setting would be indicated as medically necessary.

**PURCHASE OF A COLD THERAPY UNIT:** 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): 337-339.

**Decision rationale:** California MTUS ACOEM Guidelines would not support the purchase of a cryotherapy device in this case. While local applications of topical cold therapy are utilized to manage acute inflammation, there is no indication for the use of cryotherapy devices in the lumbar setting following surgery. This request would not be indicated as medically necessary.

**PURCHASE OF A PNEUMATIC INTERMITTENT COMPRESSION DEVICE:**  
Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: forearm/wrist/hand procedure.

**Decision rationale:** California MTUS and ACOEM Guidelines do not provide criteria relevant to this request. Under the Official Disability Guidelines, the purchase of a pneumatic intermittent compression device would be supported as medically necessary. Given the nature of the claimant's multilevel fusion process and relative immobility following the procedure, the post-operative use of a pneumatic compression device to help stimulate blood flow and minimize clotting risk would be medically indicated. The request is medically necessary and appropriate.