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| Case Number: | CM14-0133092 | | |
| Date Assigned: | 09/19/2014 | Date of Injury: | 02/14/2014 |
| Decision Date: | 11/12/2014 | UR Denial Date: | 07/29/2014 |
| Priority: | Standard | Application Received: | 08/19/2014 |

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 Preventive 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:

According to the records made available for review, this is a 36-year-old male with a 2/14/14 date of injury. At the time (6/26/14) of the request for authorization for post-operative cryotherapy 2x6 weeks QTY 12 sessions for lumbar and post-operative physical therapy 2x6 weeks for lumbar, there is documentation of subjective (intermittent moderate low back pain with radiation to the legs bilaterally, with numbness and tingling in the left foot) and objective (increased tone and tenderness about the paralumbar musculature with tenderness at the mid-line thoracic-lumbar junction and over the level of L5-S1 facets and right greater sciatic notch, muscle spasms, decreased lumbar spine range of motion, decreased sensation left L5 and S1) findings, current diagnoses (lumbar spine strain with radicular complaints), and treatment to date (medication). Medical reports identify L4-5 and L5-S1 microdiscectomy left sided and hemilaminectomy foraminotomy decompression was authorized.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post operative cryotherapy 2x6weeks QTY 12 sessions for lumbar: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/heat packs

Decision rationale: MTUS reference to ACOEM guidelines identifies at-home applications of local heat or cold to the low back as an optional clinical measure for evaluation and management of low back complaints. ODG identifies that there is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for acute pain reduction and return to normal function. Medical Treatment Guideline identifies that exact recommendations on application, for postoperative cold therapy utilization following lumbar spine surgery, on time and temperature cannot be given. Therefore, based on guidelines and a review of the evidence, the request for post operative cryotherapy 2x6 weeks QTY 12 sessions for lumbar is not medically necessary.

Post operative physical therapy 2x6 weeks for lumbar: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26. Decision based on Non-MTUS Citation Â§ 9792.24. 3. Postsurgical Treatment Guidelines; and Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Postsurgical Treatment Guidelines identifies up to 16 visits of post-operative physical therapy over 8 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS postsurgical treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine strain with radicular complaints. In addition, there is documentation that L4-5 and L5-S1 microdiscectomy left sided and hemilaminectomy foraminotomy decompression was authorized. However, the requested post operative physical therapy 2x6 weeks for lumbar exceeds guidelines (for an initial course of physical therapy following surgery). Therefore, based on guidelines and a review of the evidence, the request for post operative physical therapy 2x6 weeks for lumbar is not medically necessary.