

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0198870 | | |
| Date Assigned: | 12/09/2014 | Date of Injury: | 09/07/2006 |
| Decision Date: | 01/21/2015 | UR Denial Date: | 11/11/2014 |
| Priority: | Standard | Application Received: | 11/26/2014 |

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 Spine Surgery and is licensed to practice in New York. 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 patient has chronic low back pain. Physical examination shows antalgic gait and the patient walks with a cane. The patient is tender over the paraspinal muscles. Reflexes are 1+ at knees and ankles. Motor strength is decreased in the right hip flexors and knee extensors. Lumbar MRI showed narrowing of the lateral recess at L3-4 and L2-3. There is also spinal stenosis at L3-4 pinching nerve roots. The patient has failed conservative measures and continues to have chronic pain. Patient has had medications and physical therapy. Lumbar decompressive surgery at L2-3 and L3-4 has been approved. At issue is whether additional modalities are medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pneumatic intermittent compression device and supplies (rental or 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 and Leg Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG low back pain chapter, MTUS low back pain chapter

Decision rationale: Lumbar decompressive surgery has a very low incidence of postoperative DVT. Pneumatic intermittent compression devices for purchase of the lumbar surgery are not medically necessary. Long-term use of pneumatic intermittent compression devices of the lumbar surgery does not reduce incidence of DVT. Guidelines do not support the long-term use of lumbar pneumatic compression devices after lumbar decompressive surgery. Purchase of pneumatic DVT devices not medically necessary.

Post operative physical therapy 3x6 (lumbar): Upheld

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 MTUS chronic pain treatment guidelines, MTUS low back pain chapter

Decision rationale: MTUS postoperative physical therapy guidelines after lumbar decompressive surgery indicate that 16 visits over 8 weeks is appropriate. However, guidelines indicate that initial. Physical therapy must document functional improvement prior to approval of additional sessions. The current physical therapy request is excessive and not supported by MTUS guidelines. Initial small portion of physical therapy must be tried without improvement. 18 visits of physical therapy as requested her is not medically necessary and not supported by guidelines.

Chest x-ray: 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 Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC guidelines for preoperative testing

Decision rationale: This patient does not have documented risk factors that would warrant chest x-ray before lumbar laminectomy surgery. The patient does not smoke and does not have a past medical history of asthma pulmonary problems. The medical necessity for chest x-ray before laminectomy surgery has not been established. ODG guidelines do not support the use of chest x-ray in healthy patients with uncomplicated minor procedures such as simple laminectomy surgery.

Cold therapy unit (rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation ODG low back chapter

Decision rationale: ODG guidelines do not support the use of cold therapy of the lumbar spine decompressive surgery. Medical literature does not support the use of cold therapy after back surgery. Improve outcomes of cold therapy after lumbar laminectomy surgery has not been demonstrated in the current medical literature. Medical necessity for cold therapy after lumbar laminectomy surgery has not been established.