

Case Number:	CM15-0180645		
Date Assigned:	09/22/2015	Date of Injury:	05/01/1997
Decision Date:	10/26/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/14/2015

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: California, Oregon, Washington
 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 69 year old male, who sustained an industrial-work injury on 5-1-97. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar spinal stenosis, thoracic and lumbar neuritis and radiculitis, and post laminectomy syndrome thoracic region. Medical records dated (5-14-15 to 8-26-15) indicate that the injured worker complains of progressive bilateral radicular leg pain, constant pain in the low back with radiation of pain, and numbness and tingling to the bilateral lower extremities (BLE) and feet. The injured worker has been experiencing this pain over the last 10 years. The pain is made worse by activities and improved with lying flat, medications and rest. The pain is rated 4 out of 10 on pain scale. He also complains of insomnia due to pain. The medical records also indicate worsening of the activities of daily living. The physical exam dated 8-26-15 reveals that he has positive straight leg raising test bilaterally, there is weakness of the quads one grade out of five and ankle dorsiflexors one grade out of five. The physician indicates that "he is losing his ability to walk and has to use a caner at all times and at this point he has requested surgical care that would involve Anterior L3-4 lumbar interbody fusion with instrumentation, Removal of the posterior hardware at L4-5, and Posterior L3-4 lumbar laminectomy fusion with instrumentation." Treatment to date has included pain medication, lumbar fusion 10-18-10, decompression of epidural abscess 10-30-10, facet blocks 6-11-13, 7-11-13 and 11-8-13, history of at least 20 lumbar epidural steroid injections (ESI) with no relief, diagnostics, activity modification, rest, and other modalities. Magnetic resonance imaging (MRI) of the lumbar spine dated 7-13-15 reveals L3-L4 disc bulge with loss of disc space, facet hypertrophy, and severe

spinal stenosis and moderate bilateral neuroforaminal narrowing. The request for authorization date was 8-31-15 and requested services included Hot and cold therapy unit wrap for purchase and Associated Surgical Service: Inpatient stay 3-4 days. The original Utilization review dated 9-8-15 non-certified the request for Hot and cold therapy unit wrap for purchase as continuous flow cryotherapy is considered not medically necessary following the requested surgery per the guidelines and it is recommended in the low back section to use application of simple cold packs. The request for Associated Surgical Service: Inpatient stay 3-4 days is modified to inpatient stay times 3 days recommended as the guidelines allow for up to 3 day hospital stay for the requested procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot and cold therapy unit wrap for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd edition, Chapter 7 - Independent Medical Examinations and Consultations, page 127 The Merck Manual for Health Care Professionals; Special subjects, Care of the Surgical Patient; available at ([http://www.merckmanuals.com/professional/special/care of the surgical patient/preoperative evaluation. html](http://www.merckmanuals.com/professional/special/care_of_the_surgical_patient/preoperative_evaluation.html))..

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 section.

Decision rationale: CA MTUS/ACOEM is silent on the issue of continuous flow cryotherapy. According to the ODG Low Back section, cold/heat packs is recommended as an option for acute pain. It is recommended for at home application of cold packs for the first few days of acute complaint. The ODG does not recommend a motorized hot cold therapy unit such as vascutherm as cold packs is a low risk cost option. Therefore the determination is not medically necessary.

Associated Surgical Service: Inpatient stay 3-4 days: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic).

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 section.

Decision rationale: CA MTUS/ACOEM is silent on the issue of hospital length of stay following a lumbar fusion. According to the ODG, Low back section, Hospital length of stay, a 3 day inpatient stay is recommended following an anterior lumbar fusion. According to the ODG, Low back section, Hospital length of stay, a 3 day inpatient stay is recommended following a posterior lumbar fusion. As the request is for 3-4 days for an anterior and posterior lumbar fusion, the determination is medically necessary and appropriate.