

Case Number:	CM15-0188160		
Date Assigned:	09/30/2015	Date of Injury:	01/25/2000
Decision Date:	11/30/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/24/2015

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: Minnesota, Florida

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 52 year old male who sustained an industrial injury on 01-25-2000. Medical records indicated the worker was treated for chronic intractable axial lower back pain that radiated to the left leg, previous lumbar surgery, and rule out lumbar instability, clinical kyphosis with severe lower back pain and left leg weakness, rule out lumbar stenosis. In the provider notes of 09-09-2015, the worker is seen in follow-up pain management. He continues with chronic intractable low back pain with radiculopathy. He had previous lumbar laminectomy and recently had an updated MRI study of his lumbar spine. He is following up with an orthopedic spine surgeon for possible additional surgical intervention. He rates his pain at an 8-9 on a scale of 0-10. He relies on medication to help him with pain and states his medication provides him about 50-60 % relief of his symptoms and allows him to stay functional. Without the medication he states he is unable to get out of bed and tolerate any daily activities including showering or driving. On examination, he has moderate tenderness to palpation over the L4-5 and L5-S1 lumbar interspaces. There is muscle guarding over the bilateral erector spinae muscle and left gluteus maximus. Range of motion of the lumbar spine is limited between 40-50% with guarding. Straight-leg-raising test is positive in the left lower extremity at 45-degree angle in a sitting position. Manual testing of the lower extremities showed diminished muscle strength. A request for authorization was submitted on 09-04-2015 for a Cold compression unit for 30 days and a Lumbar wrap. Requests for lumbar spine surgery and associated services were also submitted on 09-04-2015. A utilization review decision 09-14-2015 non-certified the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold compression unit for 30 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Knee and Leg Chapter; Continuous Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Knee, Topic: Continuous flow cryotherapy.

Decision rationale: With regard to the request for cold compression unit for 30 days, ODG guidelines recommend continuous-flow cryotherapy as an option for knee and shoulder surgery postoperatively for 7 days. It reduces pain, swelling, inflammation, and the need for narcotics postoperatively. It is not recommended for back surgery. The request as stated is for 30 days which is not supported. Furthermore, the documentation provided indicates that the request for surgery was non-certified. As such, the request for cold compression unit for 30 days is not supported by evidence-based guidelines and the medical necessity of the request has not been substantiated. The request is not medically necessary.

Lumbar wrap: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Knee and Leg Chapter; Continuous Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Knee, Topic: Continuous flow cryotherapy.

Decision rationale: With regard to the lumbar wrap, since the primary surgical procedure is not medically necessary, and the cold compression unit is not medically necessary, the associated request for a lumbar wrap is also not supported. Therefore, it is neither appropriate nor necessary.