

Case Number:	CM15-0200371		
Date Assigned:	10/15/2015	Date of Injury:	04/27/2012
Decision Date:	12/03/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/13/2015

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: New York, Montana, California
 Certification(s)/Specialty: Neurological 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 53 year old female with an industrial injury dated 04-27-2012. A review of the medical records indicates that the injured worker is undergoing treatment for displacement of lumbar intervertebral disc without myelopathy, lumbosacral spondylosis without myelopathy and sciatica. According to the progress note dated 09-16-2015, the injured worker presented for reevaluation of ongoing lumbar spine pain with radiculopathy into her left greater than right lower extremities. There were no subjective complaints regarding any cardiac issues. Pain level was 6-9 out of 10 on a visual analog scale (VAS). The injured worker denied any significant past medical history. Objective findings (09-16-2015, 06-10-2015) revealed moderately to severely decrease lumbar range of motion secondary to tenderness and dysesthesia into buttocks and posterior thighs bilaterally. Physical exam also revealed that the left patellar and Achilles "DTRs" continue to be hyporeflexic and left straight leg raise continues to be positive. Treatment has included diagnostic studies, prescribed medications, and periodic follow up visits. The treating physician reported that the injured worker continues to have symptoms related to her lumbar spine and wants to proceed with the original recommended surgery. The utilization review dated 10-07-2015, non-certified the request for preoperative Chest x-rays, 2 views, and associated surgical services: PT-PTT, Vascutherm cold therapy unit without DVT, 30 day rental and modified the request for Basic metabolic profile (BMP) (original request: comprehensive metabolic profile CMP).

IMR ISSUES, DECISIONS AND RATIONALES

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

Preoperative Chest x-rays, 2 views: 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): Low Back - Preoperative testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Spinal fusion chapter-Preoperative testing, general Is NOT Medically necessary and appropriate.

Decision rationale: The ODG guidelines note that chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Documentation does not disclose pre-existing pulmonary disease. Documentation does not show how chest x-rays would affect postoperative management. The requested Treatment: Preoperative Chest X-rays, 2 views is not medically necessary.

Associated Surgical Services: CMP: 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): Low Back - Preoperative testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Spinal fusion chapter-Preoperative lab testing.

Decision rationale: The ODG guidelines note that "The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management." The requested treatment: Associated Surgical Services: CMP is not medically necessary and appropriate.

Associated Surgical Services: PT/PTT: 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): Low Back - Preoperative, lab testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Spinal Fusion Chapter -Preoperative lab testing.

Decision rationale: The ODG guidelines note that "Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants." Documentation does not disclose a history of bleeding disorders. The surgery proposed should not propose a risk of significant blood loss. The requested treatment: Associated Surgical Services: PT/PTT is not medically necessary and appropriate.

Associated Surgical Services: Vascutherm cold therapy unit without DVT, 30 day rental:
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): Knee & Leg; Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee replacement chapter-continuous flow cryotherapy.

Decision rationale: The ODG guidelines do recommend Continuous-flow cryotherapy for up to seven days. The guidelines note that "Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy." But the guidelines state "This study concluded that continuous cold therapy devices, compared to simple icing, resulted in much better nighttime pain control and improved quality of life in the early period following routine knee arthroscopy. (Woolf, 2008) Documentation does not furnish citations for treatment of post-operative back pain. The requested treatment: Associated Surgical Services: Vascutherm cold therapy unit without DVT, 30 day rental is not medically necessary and appropriate.