

Case Number:	CM15-0207497		
Date Assigned:	10/26/2015	Date of Injury:	03/25/2011
Decision Date:	12/08/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/21/2015

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: Illinois, California, Texas

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:

This injured worker is a 34-year-old female who sustained an industrial injury on 3/25/11. Injury occurred when she was opening a gate. She turned to slide the gate and experienced a pop in the low back. Past medical and surgical history was negative. Social history was positive for current every day smoking. The 5/11/15 lumbar spine MRI documented a large left paracentral disc extrusion at L5/S1 causing moderate to severe canal stenosis including complete effacement of the left lateral recess. The 9/29/15 lumbar spine X-rays documented degenerative disc disease with facet arthropathy at L5/S1. There was no instability on flexion/extension views. The 9/29/15 treating physician report cited grade 8-9/10 low back pain associated with leg pain. Lumbar spine exam documented supraspinous and iliolumbar tenderness, decreased and painful range of motion, 4/5 tibialis anterior and gastrocnemius weakness, decreased left L5 and S1 dermatomal sensation, and positive straight leg raise. She had failed extensive conservative treatment including therapy, medications, injections, and activity modification. Authorization was requested for left L5/S1 partial laminectomy and decompression with pre-operative clearance, 0-1 day hospital stay, intraoperative neurophysiologic monitoring, limb compression device, post-operative physical therapy x 12 sessions for the lumbar spine, cold therapy unit rental for 7 days, and a bone growth stimulator purchase. The 10/9/15 utilization review certified the requests for left L5/S1 partial laminectomy and decompression with pre-operative clearance, 0-1 day hospital stay, intraoperative neurophysiologic monitoring, and limb compression device. The request for 12 post-operative physical therapy sessions was modified to 8 sessions consistent with Post-Surgical Treatment Guidelines. The request for a cold therapy unit was non-certified as guidelines do not support the use of cold therapy units following lumbar spine surgery. The request for purchase of a bone stimulator was non-certified as the injured worker was not undergoing a

lumbar fusion. Records documented that the injured worker underwent a left-sided partial laminectomy of L5 and S1 with foraminotomies and decompression of the left L5 and S1 nerve roots on 10/13/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical services: Physical therapy x 12 sessions for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Low Back.

Decision rationale: The California Post-Surgical Treatment Guidelines for lumbar discectomy/laminectomy suggest a general course of 16 post-operative physical medicine visits over 8 weeks, during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 8 visits. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical period. The 10/9/15 utilization review recommended partial certification of 8 initial post-op physical therapy visits consistent with guidelines. There is no compelling reason submitted to support the medical necessity of care beyond guideline recommendations and the care already certified. Therefore, this request is not medically necessary.

Associated surgical services: Cold therapy unit x 7 days 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), Low Back Chapter, Cold/heat pack section.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

Decision rationale: The California MTUS are silent regarding cold therapy devices, but recommend at home applications of cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a cold therapy unit in the absence of guideline support and over standard cold packs. Therefore, this request is not medically necessary.

Associated surgical services: Bone growth stimulator 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 (ODG), Low Back Chapter, Bone Growth Stimulator section.

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, Lumbar & Thoracic, Bone growth stimulators (BGS).

Decision rationale: The California MTUS guidelines are silent regarding bone growth stimulators. The Official Disability Guidelines indicate that bone growth stimulators are under study and may be considered medically necessary as an adjunct to lumbar spinal fusion surgery for patients with any of the following risk factors for failed fusion: 1) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit; (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. Guideline criteria have not been met. This injured worker underwent a lumbar laminectomy and foraminotomy at L5/S1. The use of a bone growth stimulator is supported following lumbar fusion surgery. In the absence of a fusion procedure, the basic indications for use are not met. Therefore, this request is not medically necessary.