

<b>Case Number:</b>	CM15-0216161		
<b>Date Assigned:</b>	11/06/2015	<b>Date of Injury:</b>	12/10/2004
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	10/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2015

### 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: Texas, California

Certification(s)/Specialty: Family Practice

### 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 73 year old male, who sustained an industrial injury on December 10, 2004, incurring low back. He was diagnosed with multilevel lumbar spine discopathy with spondylolisthesis. Treatment included pain medications, lumbar epidural steroid injection, transcutaneous electrical stimulation unit, physical therapy, and activity restrictions. Currently, the injured worker complained of persistent low back pain. He was only able to walk a short way before his legs would go numb. He was noted to have weakness, decreased sensation and spasms in the lower back and legs. Magnetic Resonance Imaging revealed lumbar disc protrusions effacing the thecal sac and nerve roots. He was referred for a surgical lumbar fusion with decompression. The treatment plan that was requested for authorization included an ice unit for the lumbar spine for post-operative use; and a post-operative home evaluation by an RN for the first 24 hours home. On October 9, 2015, a request for an ice unit for the lumbar spine was modified for 7 day post -operative use by utilization review and a request for a home evaluation by an RN was denied by utilization review. The patient had received an unspecified number of PT visits for this injury. The patient had used a TENS unit for this injury. The patient had received lumbar ESI for this injury. Per the note dated 9/18/15 the patient had complaints of low back pain and numbness in leg. Physical examination of the lumbar spine revealed tenderness on palpation, muscle spasm and diminished sensation. The patient has had MRI of the lumbar spine on 2/17/09 that revealed disc protrusions, foraminal narrowing. The patient was certified for lumbar fusion on 10/7/15. Whether the patient underwent lumbar surgery or not was not

specified in the records specified. The request for Ice unit for lumbar spine for post operative use was modified for 7 days rental.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Ice unit for lumbar spine for post operative use: 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 Chapter.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 12/02/15) Cold/heat packs Knee & Leg (updated 07/10/15) Continuous-flow cryotherapy.

**Decision rationale:** Per the ACOEM guidelines cited below "At-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold." Per the cited guidelines Continuous-flow cryotherapy is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use...The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting. There is limited information to support active vs passive cryo units. Cryotherapy after TKA yields no apparent lasting benefits, and the current evidence does not support the routine use of cryotherapy after TKA." Per the cited guidelines cold packs is "Recommended as an option for acute pain." At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. There is minimal evidence supporting the use of cold therapy. Therefore there is minimal evidence supporting the use of cold therapy for this diagnosis. The rationale for not using a simple cold pack at home was not specified in the records provided. The patient has received an unspecified number of the PT visits for this injury till date. The records provided do not specify a detailed response to conservative measures including PT for this injury. Evidence of diminished effectiveness of medications or intolerance to medications is not specified in the records provided. The cited guideline recommend postoperative use of Continuous-flow cryotherapy generally up to 7 days. The duration of the proposed use of the ice unit in this patient was not specified in the records provided. The request for Ice unit for lumbar spine for post operative use is not medically necessary in this patient.

#### **Post operative home evaluation by RN after the first 24 hours home: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

**Decision rationale:** Per the CA MTUS guidelines cited below, regarding home health services "Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week." He was diagnosed with multilevel lumbar spine discopathy with spondylolisthesis. Currently, the injured worker complained of persistent low back pain. He was only able to walk a short way before his legs would go numb. He was noted to have weakness, decreased sensation and spasms in the lower back and legs. Magnetic Resonance Imaging revealed lumbar disc protrusions effacing the thecal sac and nerve roots. He was referred for a surgical lumbar fusion with decompression. The patient was certified for lumbar fusion on 10/7/15. Post operatively after a lumbar fusion surgery, the patient would be expected to have difficulty with ambulation. In this 73 year old patient a post operative home evaluation by a RN would help with the safe transitioning of this patient's care to his home. The Post operative home evaluation by RN after the first 24 hours home following lumbar fusion is medically necessary.