MAXIMUS Federal Services

Case Number:	CM15-0042900		
Date Assigned:	03/13/2015	Date of Injury:	09/24/2013
Decision Date:	05/01/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	03/06/2015

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: Oregon, 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 55-year-old female who reported an injury on 09/24/2013. The mechanism of injury involved a fall. The current diagnosis is right SI joint disruption. The injured worker presented on 01/26/2015 for a follow-up evaluation. It was noted that the injured worker was status post a right sacroiliac joint injection. The injured worker reported an improvement in symptoms for several days following the injection. The injured worker presented with complaints of 8/10 right sided buttock and leg pain. It was also noted that the injured worker was status post L3-4 fusion as well as an ACDF (dates unknown). The injured worker was utilizing Flexeril, Nucynta, and Percocet. Upon examination, there was diffuse tenderness in the cervical spine, mild to moderately decreased cervical range of motion, lower lumbosacral tenderness on the right buttock region, dysesthesia in the right leg, markedly positive right straight leg raise, decreased sensation in the left upper extremity as well as the right lower extremity, diminished reflexes in the bilateral upper and lower extremities, positive Fortin finger test on the right, positive Gaenslen's and faber test on the right, severe right buttock and hip pain with pelvic compression testing, and an antalgic gait. Treatment recommendations at that time included a sacroiliac fusion. A Request for Authorization form was then submitted on 01/28/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Rental of vascutherm cold therapy unit x 14 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, Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Continuous flow cryotherapy.

Decision rationale: The Official Disability Guidelines do not recommend continuous flow cryotherapy for the spine. Continuous flow cryotherapy is recommended following surgical procedures for the upper and lower extremities for up to 7 days following surgery. The current request for a 14 day rental would exceed guideline recommendations. However, the Official Disability Guidelines would not support the use of a continuous flow cryotherapy unit in this case. As such, the request is not medically appropriate.

Associated surgical service: Rental of bone growth stimulator unit x 14 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, Knee Chapter, Bone growth stimulators.

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 Chapter, Bone growth stimulator (BGS).

Decision rationale: The Official Disability Guidelines recommend a bone growth stimulator following a spinal fusion for patients with risk factors for a failed fusion. The injured worker does not meet any of the criteria outlined by the Official Disability Guidelines. There was no evidence of a previous failed spinal fusion or spondylolisthesis. There was no indication that a fusion will be performed at more than 1 level. There was no documentation of any significant comorbidities, medical history, or a current smoking habit. Given the above, the medical necessity has not been established. As such, the request is not medically appropriate.

Post-op physical therapy x 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10 and 23.

Decision rationale: The California MTUS Guidelines state the initial course of therapy means 1 half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations. Postsurgical treatment following

an arthrodesis includes 22 visits over 3 months. The current request for an initial 12 sessions of postoperative physical therapy would exceed guideline recommendations. As such, the request is not medically appropriate at this time.