MAXIMUS Federal Services

Case Number:	CM15-0072569		
Date Assigned:	04/22/2015	Date of Injury:	07/05/2013
Decision Date:	08/14/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	04/16/2015

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
Certification(s)/Specialty: Anesthesiology

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 24 year old male, who sustained an industrial injury on July 5, 2013. The injured worker has been treated for low back complaints. The diagnoses have included lumbar radiculopathy and extruded protrusion lumbar four-lumbar five. Treatment to date has included medications, radiological studies, and physical therapy and epidural steroid injections. Current documentation dated April 1, 2015, notes that the injured worker reported low back pain. Physical examination of the lumbar spine revealed tenderness to palpation over the paravertebral muscles and a painful and decreased range of motion. A straight leg raise and rectus femoris stretch sign did not demonstrate any nerve irritability. The treating physician recommended lumbar spine surgery. The treating physician's plan of care included a request for pre-operative clearance, lumbar/sacral orthosis back brace, post-operative physical therapy, motorized cold therapy unit rental, home nursing for dressing changes and home therapy # 6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-operative clearance, Pre-op labs (CBC, BMP, PT, PTT, UA) and EKG, chest x-rays with Dr. Shahriar Ghodsian: Upheld

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

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

Decision rationale: According to the ACOEM Guidelines, medical clearance/history and physical can be provided by the surgeon prior to the procedure. In this case, the patient has no co-morbidities and pre-operative testing should include a CBC, CMP, PT, PTT, and UA. In this case, the patient is a 24 year old male with no health history to suggest an indication for an EKG or chest x-ray. Therefore, medical necessity for all of the requested services has not been established. The requested services are not medically necessary.

LSO brace: Upheld

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

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.

Decision rationale: According to the ODG, an LSO brace is indicated status post lumbar fusion. In this case, the patient is to undergo a micro-discectomy at L4-5. The ODG would recommend an elastic lumbar belt for non-specific low back pain. Medical necessity for the requested LSO brace has not been established. The requested item is not medically necessary.

Post-op physical therapy two (2) times a week for six (6): Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Physical therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. A recent Cochrane review concluded that exercise programs starting 4-6 weeks post-surgery seem to lead to a faster decrease in pain and disability than no treatment; high intensity exercise programs seem to lead to a faster decrease in pain and disability than low intensity programs; home exercises are as good as supervised exercises; and active programs do not increase the re-operation rate. Although it is not harmful to return to activity after lumbar disc surgery, it is still unclear what exact components should be included in rehabilitation programs. High intensity programs seem to be more effective but they could also be more expensive. Another question is whether all patients should be treated post-surgery or is a minimal intervention with the message to return to an active lifestyle sufficient, with only patients that still have symptoms 4 to 6 weeks post-surgery requiring rehabilitation programs. There is inconclusive evidence for the effectiveness

of evidence from two trials suggested that intervention might reduce disability short-term, and more intensive intervention may be more beneficial than less intensive therapy, pooled results did not show statistically significant benefit. The ODG and MTUS support up to 16 sessions of post-operative physical therapy over 8 weeks. Medical necessity for the PT visits requested (2x6) has been established. The requested services are medically necessary.

Motorized cold therapy unit two (2) week rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cold/heat packs.

Decision rationale: According to the ODG, the home application of cold packs is just as effective as those performed by a therapist. A motorized cold therapy unit is not supported status post lumbar surgery. If cold therapy is desired, cold packs are readily available. There is no specific indication for a motorized cold therapy unit. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Home nursing - dressing changes daily for two (2) weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: According to the CA MTUS, home health/nursing services are recommended for patients who are home-bound, on a part-time or intermittent basis, generally up to no more than 35 hours per week to administer medical treatment. In this case, the patient is a 24-year old with no documentation of any deficits or lack of a social support system that would require home nursing or in-home therapy, status post a micro-discectomy at L54-5. Medical necessity for the requested service has not been established. The requested home nursing is not medically necessary.

Home therapy three (3) times a week for two (2) weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: According to the CA MTUS, home health/nursing services are recommended for patients who are home-bound, on a part-time or intermittent basis, generally up to no more than 35 hours per week to administer medical treatment. In this case, the patient is a 24-year old with no documentation of any deficits or lack of a social support system that would require home nursing or in-home therapy, status post a micro-discectomy at L54-5. Medical necessity for the requested service has not been established. The requested home nursing is not medically necessary.