

Case Number:	CM15-0083311		
Date Assigned:	05/05/2015	Date of Injury:	11/29/1999
Decision Date:	08/06/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	04/30/2015

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: California

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:

The injured worker is a 71 year old male, who sustained an industrial injury on 11/29/1999. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having cervical spine musculoligamentous sprain/strain with spondylosis, right shoulder sprain/strain with tendinitis, bursitis, and impingement with acromioclavicular joint osteoarthritis, status post bilateral carpal tunnel release with status post left wrist carpal fusion and bilateral thumb basal osteoarthritis, lumbar spine musculoligamentous sprain/strain with right lower extremity radiculitis and spondylosis, bilateral knee patellofemoral arthralgia with chondrocalcinosis, bilateral ankle sprain/strain with right Achilles tendinitis, and right elbow medial and lateral epicondylitis with probable carpal tunnel syndrome. Treatment to date has included magnetic resonance imaging of the cervical spine, x-rays of the right shoulder, lumbar spine, and bilateral knees, medication regimen, home exercise program, above listed procedure, magnetic resonance imaging of the lumbar spine, physical therapy, and epidural steroid injections. In a progress note dated 01/16/2015 the treating physician reports complaints of constant mild to moderate, sharp, aching pain to the bilateral knee with the left greater than the right along with lower extremity fatigue and buckling to the left side that gives away. The pain is rated a five to six on a scale of zero to ten. The treating physician also notes that the injured worker has intermittent pain to the lumbar spine that radiates into the legs with a pain along with weakness. The pain is rated a seven out of ten. The injured worker also has tenderness to palpation to the peri-patellar region along with tenderness to palpation to the lumbar paravertebral muscles, and a decreased sensation to the

right ankle. Lumbar magnetic resonance imaging as noted in progress note from 01/16/2015 was remarkable for severe bilateral facet arthropathy with severe spinal canal cauda equine at lumbar three through lumbar five. The treating physician requested lumbar three to four and lumbar four to five decompression with associated surgical services of pre-operative medical clearance, twelve sessions of supervised post-operative rehabilitation therapy, a Game Ready/cold unit, a thoracolumbosacral orthosis brace, a front wheel walker, and a three in one commode.

IMR ISSUES, DECISIONS AND RATIONALES

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

One L3-L4 and L4-L5 decompression: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 310. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic (Acute & chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 308-310. Decision based on Non-MTUS Citation ODG Low back, Discectomy/Laminectomy.

Decision rationale: CA MTUS/ACOEM Low back complaints, pages 308-310 recommends surgical consideration for patients with persistent and severe sciatica and clinical evidence of nerve root compromise if symptoms persist after 4-6 weeks of conservative therapy. According to the ODG Low Back, discectomy/laminectomy criteria, decompression is indicated for correlating distinct nerve root compromise with imaging studies. In this patient there is evidence of lumbar radiculopathy from the exam note of 1/16/15 correlating with the MRI of the lumbar spine. Therefore the guideline criteria have been met and the request is medically necessary.

Associated surgical services: One pre-op medical clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aaos.org/about/papers/position/1120.asp>.

Decision rationale: CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, "These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgeries who have

additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is 71 year old and does warrant preoperative testing prior to the proposed surgical procedure. Therefore the request is medically necessary.

Associated surgical services: Twelve supervised post-operative rehabilitation therapy sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical fee Schedule, 1999 edition, pages 92-93.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): s 25-26.

Decision rationale: Per the guidelines; Intervertebral disc disorders without myelopathy recommends: For Postsurgical treatment (discectomy/laminectomy) the treatment period is 16 visits over 8 weeks. For Postsurgical physical medicine the treatment period is 6 months. In this case the request exceeds the 1/2 initial recommendation of 8 visits. Therefore the request is not medically necessary.

Associated surgical services: One game ready/cold unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic (Acute & Chronic), Cold/Heat packs.

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 section, Cold/Heat packs.

Decision rationale: CA MTUS/ACOEM is silent on the issue of continuous flow cryotherapy. According to the ODG Low Back section, cold/heat packs is recommended as an option for acute pain. It is recommended for at home application of cold packs for the first few days of acute complaint. The ODG does not recommend a motorized hot cold therapy unit such as vascutherm as cold packs is a low risk cost option. Therefore the request is not medically necessary.

Associated surgical services: One TSLO brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic), Walking Aids (canes, crutches braces, orthoses, & walkers), Durable Medical Equipment.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: CA MTUS/ACOEM guidelines, Chapter 12, page 301 states, "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." Therefore the request does not meet recommended guidelines and is not considered medically necessary.

Associated surgical services: One front wheel walker: 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 & Leg (Acute & Chronic), Walking Aids (canes, crutches braces, orthoses, & walkers), Durable Medical Equipment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids.

Decision rationale: CA MTUS/ACOEM is silent on the issue of walking aids. According to the ODG, Knee and Leg, Walking aids, is recommended for patients with osteoarthritis. In this case there is insufficient evidence from the records from 1/16/15 of significant osteoarthritis or functional impairment to warrant a front wheel walker. Therefore the request is not medically necessary.

Associated surgical services: One 3-in-1 commode: 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 & Leg (Acute & Chronic), Walking Aids (canes, crutches braces, orthoses, & walkers), Durable Medical Equipment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, DME toilet items.

Decision rationale: CA MTUS/ACOEM is silent on the issue of commode. Per the ODG Knee and Leg, DME toilet items (commodes, bed pans, etc.) are medically necessary if the patient is bed- or room-confined, and devices such as a raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. In this case the exam note from 1/16/15 does not demonstrate any functional limitations to warrant a commode postoperatively. Therefore the request is not medically necessary.