

<b>Case Number:</b>	CM14-0092519		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	01/29/2009
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	06/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2014

### 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. The expert reviewer is Board Certified in Orthopedic Spine Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 58-year-old female who reported injury on 01/29/2009. The mechanism of injury was the injured worker was leaning over a food counter to serve a student in the cafeteria. The prior surgical history included an L5-S1 fusion on 11/23/2010 and L3-S1 partial removal of hardware and fusion on 10/18/2011. Prior diagnostic studies were noted to include an electrodiagnostic study on 10/05/2012 and a CT of the lumbar spine, as well as an MRI of the lumbar spine. The prior treatments were noted to include narcotic medications, physical therapy, nerve blocks and injections, and epidural steroid injections. The documentation indicated that the injured worker was approved for a lateral interbody fusion at L2-3, laminectomy L2-3, posterior spinal fusion L2-3, a removal of hardware and exploration of fusion at L3-S1. The injured worker's medical history included hypertension, diabetes, restless leg syndrome, depression, anxiety, thyroid disease, and GERD, and the injured worker was noted to be a current smoker. The request for authorization dated 05/16/2014 revealed a diagnosis of post laminectomy syndrome of the lumbar region and multiple prescriptions, as well as request for authorizations including an assistant surgeon, preoperative labs CBC, CMP, UA, and x-ray of the chest, rental of a motorized cold therapy unit x2 weeks, and a rental and purchase of an adjustable bed. There was no physical examination note submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Assistant surgeon:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment in Workers' Compensation (TWC)Low Back Procedure Summary last updated 3/31/14.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Low Back Chapter, Surgical assistant.

**Decision rationale:** The Official Disability Guidelines indicate a surgical assistant is recommended as an option in more complex surgeries, including the approved surgical interventions. The surgical intervention was approved and as such, the request for an assistant surgeon is medically necessary.

**Pre-operative labs CBC, BMP, UA, and X-ray Chest:** 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) - Treatment in Workers' Compensation (TWC)Low Back Procedure Summary last updated 3/31/14.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Low Back Chapter, Preoperative lab testing, Preoperative testing, general.

**Decision rationale:** The Official Disability Guidelines indicate that electrolyte and creatinine testing should be performed in injured workers with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure, and a complete blood count is indicated for injured workers with diseases that increase the risk of anemia or injured workers in whom significant perioperative blood loss is anticipated. There was a lack of documented rationale for the requested testing. The Official Disability Guidelines indicate that preoperative urinalysis is recommended for injured workers undergoing invasive neurologic procedures and those undergoing implantation of foreign material. There was a lack of documented rationale for the requested urinalysis. Additionally, the Official Disability Guidelines indicate that chest radiography is reasonable for injured workers at risk of postoperative pulmonary complications if the result would change perioperative management. There was a lack of documented rationale for a chest x-ray. There was no physician note submitted for review to support the requested procedures. Given the above, the request for preoperative labs, CBC, BMP, UA, and x-ray chest is not medically necessary.

**Rental of motorized cold therapy unit - 2 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment in Workers' Compensation (TWC)Low Back Procedure Summary last updated 3/31/14.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation (ODG) Low Back Chapter, Ice Packs/Heat packs.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate that at home local applications of cold in the first few days of acute complaint are appropriate in the applications of heat or cold. The Official Disability Guidelines support the same treatment. There was a lack of documentation indicating a necessity for a motorized unit versus hot/cold packs. Given the above and the lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations, the request for rental of motorized cold therapy unit 2 weeks is not medically necessary.

**Rental and purchase of adjustable bed:** 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 (ODG) Low Back Chapter, Mattress Selection, Knee & Leg Chapter, DME.

**Decision rationale:** The Official Disability Guidelines indicate that mattress selection is dependent upon injured worker's preference and individual factors. However, a bed is durable medical equipment. As such, the durable medical guidelines would apply. The Official Disability Guidelines indicate that durable medical equipment is recommended if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment, including the equipment could withstand repeated use, as in could normally be rented and used by successive patients, as primarily and customarily used to serve a medical purpose and is generally not useful to a person in the absence of illness or injury, as well as is appropriate for use in an injured worker's home. There was a lack of documentation meeting the above criteria. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. There was a lack of documentation indicating a necessary for both a rental and purchase of an adjustable bed. Given the above, the request for rental and purchase of adjustable bed is not medically necessary.