

Case Number:	CM14-0209428		
Date Assigned:	12/22/2014	Date of Injury:	12/15/2011
Decision Date:	02/27/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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
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 56-year-old female who reported injury on 12/15/2011. The mechanism of injury was cumulative trauma. Prior therapies included an MRI, carpal tunnel release surgery, cervical fusion surgery, acupuncture, physical therapy, epidural steroid injections and a TENS unit. The documentation of 04/30/2014 revealed the request was for an anterior cervical discectomy and fusion at C4-7. The physician documented the MRI revealed at C4-5 there was a 4.5 mm herniated nucleus pulposus, broad based disc C5-6 spinal stenosis and neural foraminal narrowing at C6-7. The documentation of 06/11/2014 revealed the injured worker had complaints of severe shoulder pain, bilateral elbow pain and wrist pain, neck pain and low back pain. It was indicated the injured worker had continued pain in the neck and had approval for surgery. The examination of the cervical spine revealed spasms, and painful and decreased range of motion. There was facet tenderness. There was decreased sensation in the bilateral C4-7. There was tenderness to palpation at the cervicotrachezial ridge. The injured worker had neck pain radiating into the bilateral arms, with right arm cross C6-7 distribution, right greater than left. There was decreased sensation on the right at C6 level. Thumb pain radiation was worse at C6 and to the middle finger at C7. Numbness across the right deltoid compared to the left at the level of C5. The examination of the lumbar spine revealed painful and limited range of motion and a positive Lasegue's bilaterally. There was a positive straight leg raise bilaterally to 60 degrees. There was decreased sensation bilaterally at L4-5 and L5-S1. There was pain bilaterally at L4-5 and L5-S1. There was tenderness to palpation over the lumbar paraspinal musculature. The examination of the right shoulder revealed a positive impingement sign. There was painful range of motion on

the right. The forward flexion and abduction were to 120 degrees. There was tenderness to palpation at the AC joint. Examination of the wrist and hands revealed healed scars bilaterally. The injured worker had a positive Tinel's, Phalen's and Durkin compression test. The injured worker had decreased grip strength. The examination of the elbow and forearm revealed a positive Tinel's bilaterally. There was tenderness laterally and medial in the epicondyle. The diagnoses included cervical strain; cervical discogenic disease; right upper extremity radiculitis; right shoulder impingement syndrome; bilateral epicondylitis, lateral elbow; bilateral ulnar neuritis, right greater than left; bilateral carpal tunnel syndrome with recurrence on right, status post carpal tunnel release 1994; lumbar discogenic disease; and mechanical low back pain with nonradicular findings. The treatment plan included scheduling surgery as soon as possible, and a refill of Ultram ER 150 mg 2 tablets daily #60 for pain and Prilosec 20 mg 1 tablet twice a day #60 for GI upset. The injured worker had refill of Lidoderm patches 5% 1 every 12 hours on and off #30. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Cellsaver Machine Rental DOS: 07/25/2014: 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, Integrated Treatment / Disability Duration Guidelines, Knee & Leg (Acute & Chronic) (updated 12/28/12)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Roger Kirk Owens, I. I., Crawford III, C. H., Djurasovic, M., Canan, C. E., Burke, L. O., Bratcher, K. R., ... & Carreon, L. Y. (2013). Predictive factors for the use of autologous cell saver transfusion in lumbar spinal surgery. *Spine*, 38(4), E217-E222.

Decision rationale: Per Roger Kirk Owens, et. al. (2013), "The use of autologous cell saver transfusion did not reduce the requirement for intraoperative or postoperative allogeneic blood transfusion." The clinical documentation submitted for review failed to provide a documented rationale for the use of a cell saver. There was a lack of documentation of exceptional factors. Given the above, the request for retro cellsaver machine rental DOS: 07/25/2014 is not medically necessary.

Retro surgical supplies: 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) Knee & Leg Chapter, Durable medical equipment (DME).

Decision rationale: The Official Disability Guidelines indicate that durable medical equipment is appropriate when it meets the guidelines including that it is equipment which can withstand repeated use, could no longer be rented and used by successive patients, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the patient's home. The request as submitted failed to provide the specific surgical supplies that were being requested. As such, durable medical equipment guidelines were not met. Given the above, the request for retro surgical supplies is not medically necessary.

Retro Technician 4 hours DOS: 07/25/2014: 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 Other Medical Treatment Guideline or Medical Evidence: Roger Kirk Owens, I. I., Crawford III, C. H., Djurasovic, M., Canan, C. E., Burke, L. O., Bratcher, K. R., ... & Carreon, L. Y. (2013). Predictive factors for the use of autologous cell saver transfusion in lumbar spinal surgery. *Spine*, 38(4), E217-E222.

Decision rationale: Per Roger Kirk Owens, et. al. (2013), "The use of autologous cell saver transfusion did not reduce the requirement for intraoperative or postoperative allogeneic blood transfusion." The clinical documentation submitted for review failed to provide a documented rationale for the use of a cell saver. There was a lack of documentation of exceptional factors. Given the above, the request for retro technician 4 hours DOS: 07/25/2014 is not medically necessary.

Retro Blood Collected, Processed & Storage DOS: 07/25/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Roger Kirk Owens, I. I., Crawford III, C. H., Djurasovic, M., Canan, C. E., Burke, L. O., Bratcher, K. R., ... & Carreon, L. Y. (2013). Predictive factors for the use of autologous cell saver transfusion in lumbar spinal surgery. *Spine*, 38(4), E217-E222.

Decision rationale: Per Roger Kirk Owens, et. al. (2013), "The use of autologous cell saver transfusion did not reduce the requirement for intraoperative or postoperative allogeneic blood transfusion." The clinical documentation submitted for review failed to provide a documented rationale for the use of a cell saver. There was a lack of documentation of exceptional factors. Given the above, the request for retro blood collected, processed & storage DOS: 07/25/2014 is not medically necessary.