

Case Number:	CM14-0040533		
Date Assigned:	06/20/2014	Date of Injury:	01/16/2006
Decision Date:	01/02/2015	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	03/10/2014

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 Surgeon 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 54-year-old male who reported an injury on 01/16/2006. The mechanism of injury was not stated. The current diagnoses include right knee pain, status post spinal cord stimulator on 07/22/2012, revision of spinal cord stimulator on 10/22/2012, status post right S1 laminotomy and re-exploration on 12/13/2011, L3 through S1 facet arthropathy, multilevel lumbar degenerative disc disease, right S1 radiculopathy, and status post anterior and posterior fusion with total disc arthroplasty at L2-3 on 11/29/2010. The injured worker presented on 02/10/2014 with complaints of ongoing lower back pain. It is noted that the injured worker underwent a right sided L5 selective nerve root block on 01/31/2014 which provided no relief of symptoms and a flare up of pain. The current medication regimen includes fentanyl 75 mcg, Dilaudid 8 mg, and Lithium 300 mg, Prozac 40 mg, and Xanax 0.5 mg, and Zanaflex 4 mg. The physical examination revealed an antalgic gait, tenderness to palpation of the paravertebral muscles bilaterally, decreased sensation in the right L5 dermatome and left L4-5 dermatome, and weakness in the bilateral lower extremities with a positive straight leg raise on the right. Treatment recommendations at that time included an L5 laminotomy and foraminotomy, pre-surgical medical clearance, postoperative durable medical equipment, and postoperative physical therapy. There was no Request for Authorization form submitted for this review. It is noted that the injured worker was issued authorization for a lumbar laminectomy on 02/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar-Sacral Orthosis (LSO) Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

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, Back brace, postoperative (fusion).

Decision rationale: The Official Disability Guidelines state a postoperative back brace is currently under study, and given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom postoperative brace. There is no documentation of any recent lumbar fusion surgeries. Therefore, the current request cannot be determined as medically appropriate in this case.

Cold Therapy Unit x 30 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

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 Chapter, Continuous flow cryotherapy.

Decision rationale: The Official Disability Guidelines do not recommend continuous flow cryotherapy for the spine. It is recommended for postoperative use following shoulder and knee surgery. Therefore, the current request cannot be determined as medically appropriate in this case.

Pneumatic Intermittent Compression Device: 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), Knee and Leg chapter

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, Venous Thrombosis.

Decision rationale: The Official Disability Guidelines recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. There is no indication that this injured worker is at high risk of developing a venous thrombosis. There is also no mention of a contraindication to oral anticoagulation therapy as opposed to a motorized mechanical device. The duration of treatment was also not listed in the request. Therefore, the request is not medically appropriate.

Post-Op Physical Therapy (PT): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 26.

Decision rationale: The California MTUS Guidelines state the initial course of therapy means one 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 a lumbar laminectomy includes 16 visits over 8 weeks. There was no quantity listed in the current request. Therefore, the request is not medically appropriate.

3-day Inpatient stay: 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), Low Back - Lumbar & Thoracic (Acute & Chronic): Hospital length of stay (LOS)

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, Hospital Length of Stay (LOS).

Decision rationale: The Official Disability Guidelines state the median length of stay following a lumbar laminectomy includes 2 days. The current request for a 3 day inpatient stay exceeds guideline recommendations. Therefore, the request is not medically appropriate at this time.