MAXIMUS Federal Services

Case Number:	CM15-0014887		
Date Assigned:	02/02/2015	Date of Injury:	01/26/2013
Decision Date:	05/27/2015	UR Denial Date:	01/13/2015
Priority:	Standard	Application Received:	01/26/2015

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: Minnesota, Florida
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 54-year-old male, with a reported date of injury of 01/26/2013. The diagnoses include L5-S1 stenosis with radiculitis, low back pain with right-sided radiculopathy, status post lumbar laminectomy, status post right-sided L5-S1 discectomy, and prolapsed lumbar intervertebral disc. Treatments to date have included an MRI of the lumbar spine. The progress report dated 12/23/2014 indicates that the subjective findings included pain rated 9 out of 10. It was noted that the injured worker's symptoms were worse. The objective findings include an antalgic gait, normal alignment of the lumbar spine, tenderness of the iliolumbar region, pain with motion of the lumbar spine, decreased sensation on the sole of the right foot and posterior leg, and positive seated straight leg raise test. The treating physician recommended a revision decompression at L5-S1. The treating physician requested the associated surgical services: a cold therapy unit and intraoperative monitoring. The surgery was certified by utilization review but the cold therapy unit and intraoperative monitoring were noncertified. The UR rationale for non-certification was not included with the medical records submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical services: One cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation ODG: Section: Low Back, Topic: Cold/heat packs.

Decision rationale: California MTUS and ODG guidelines recommend cold packs. However, continuous flow cryotherapy is not recommended for the lower back. It is used for other body parts such as the shoulder and knee for 7 days after surgery. As such, the request for a cold therapy unit for the lower back is not supported and the medical necessity of the request has not been substantiated. Therefore, the requested medical treatment is not medically necessary.

Associated surgical services: Intraoperative monitoring: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Low Back, Topic: Intraoperative neurophysiological monitoring.

Decision rationale: ODG guidelines recommend intraoperative neurophysiological monitoring during surgery for spinal procedures when such procedures have a risk of significant complications that can be detected and prevented through use of neurophysiological monitoring. The guidelines state that in the majority of routine orthopedic spine procedures, mostly laminectomy, discectomy, or spinal fusion surgeries the use of monitoring should be at the discretion of the surgeon. The surgeon has requested the monitoring for a revision lumbar spine decompression. As such, the request is supported by guidelines and the medical necessity of the request has been substantiated. Therefore, the requested medical treatment is not medically necessary.