

Case Number:	CM15-0126458		
Date Assigned:	07/13/2015	Date of Injury:	05/19/2005
Decision Date:	08/10/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	06/30/2015

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: Illinois, California, 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 67-year-old male who sustained an industrial injury on 5/19/05, relative to repetitive work activities as a fire fighter. The 3/10/15 lumbar spine MRI impression documented L3/4 disc desiccation with central disc protrusion and ventral narrowing of the thecal sac, significant narrowing of the right lateral recess and mild left lateral recess narrowing. At L4/5, there was disc desiccation with central disc protrusion and ventral narrowing of the thecal sac, and significant bilateral lateral recess narrowing. At L5/S1, there was disc desiccation with central disc protrusion and ventral narrowing of the thecal sac, and mild bilateral lateral recess narrowing. The 5/13/15 treating physician report cited severe low back pain radiating into the lower extremities, with associated numbness and tingling. Difficulty was reported with prolonged sitting, standing and walking, activities of daily living, and sleep. Lumbar spine exam documented restricted range of motion, decreased L4, L5, and S1 dermatomal sensation, weakness over the L4, L5, and S1 innervated muscles, and asymmetric patellar reflexes. X-rays showed significant disc space collapse from L3 through S1 with bone on bone erosion, and resultant segmental instability at L3/4, L4/5, and L5/S1. The diagnosis included lumbar discopathy with radiculitis. The injured worker had failed conservative treatment. Authorization was requested for L3 through S1 posterior lumbar interbody fusion (PLIF) with instrumentation, front wheeled walker, ice unit, TLSO (thoracolumbosacral orthosis), 3 in 1 commode, medical clearance, 2-3 day inpatient stay, and assistant surgeon. The 6/17/15 utilization review certified the L3 through S1 PLIF with instrumentation and associated surgical requests, except the ice unit. The ice unit was modified to 7-day rental based on the Official Disability Guidelines for shoulder and knee surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ice 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 (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

Decision rationale: The California MTUS are silent regarding cold therapy devices, but recommend at home applications of cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of cold packs for patients with low back complaints. Guideline criteria have not been met. The 6/17/15 utilization review modified the request for an ice unit to a 7-day rental. There is no compelling reason submitted to support the medical necessity of a hot/cold therapy unit in the absence of guideline support, and beyond the post-operative 7-day use previously certified. Therefore, this request is not medically necessary.