

Case Number:	CM15-0062718		
Date Assigned:	04/08/2015	Date of Injury:	06/25/2013
Decision Date:	05/19/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	04/02/2015

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 36-year-old male who sustained an industrial injury on 6/25/13. He reported a sharp sudden pain between his shoulder blades while driving his patrol vehicle. The 1/4/13 lumbar spine MRI impression documented focal 3-4 mm right paracentral disc protrusion at L4/5 causing mild right lateral recess narrowing with superior extension. There as mild right neuroforaminal narrowing and mild bilateral facet hypertrophy. There was 3-4 mm left paracentral disc herniation with annular tear at the L3/4 level causing left lateral recess narrowing with posterior displacement of the traversing left L4 nerve root. There was a 2 mm right paracentral disc bulge at the L2/3 level, causing no significant neuroforaminal narrowing or canal stenosis. There was a 2 mm broad-based disc bulge at L5/S1 causing no significant neuroforaminal narrowing or canal stenosis. The 2/19/15 treating physician report reported that the injured worker experience severe low back spasms that caused him to fall coming out of the shower yesterday onto his back. He reported low back pain radiating down both legs. Physical exam documented increased lumbosacral spinal tone and spasms, with tenderness over the paralumbar muscles, midline thoracolumbar junction, and over the L5/S1 facets and right sciatic notch. Straight leg raise was positive on the right. There was 4-/5 right and 4/5 left anterior tibialis, 3/5 right and 4+/5 left extensor hallucis longus, 4-/5 right gastrocsoleus weakness, and 4/5 bilateral peroneal muscle weakness. Lower extremity reflexes were 1+ over the left Achilles, and absent over the patellar and bilateral Achilles. Sensation was decreased over the right L4 and L5 dermatomes. The injured worker was ambulating with a walker. The 4/7/14 lumbar spine MRI showed 2-3 mm posterior disc bulge at L4/5 with mild thecal sac narrowing and right

neuroforaminal narrowing. At L5/S1, there was a 3-4 mm posterior disc bulge with mild thecal sac narrowing and mild bilateral neuroforaminal narrowing. Conservative treatment included epidural steroid injection, chiropractic treatment, physical therapy, medications, and activity modification had failed to provide sustained improvement. Authorization was requested for L4/5 and L5/S1 microdiscectomy right sided and hemilaminectomy, foraminotomy, and decompression. The 3/24/15 utilization review modified the request for right L4/5 and L5/S1 microdiscectomy and hemilaminectomy, foraminotomy, decompression and allowed right L4/5 microdiscectomy and hemilaminectomy, foraminotomy decompression. The rationale for non-certification of surgery at the L5/S1 level was based on no imaging evidence of stenosis at the L5/S1 level. Associated requests included certification for post-op physical therapy 2x6. The request for post-operative cryotherapy 2x6 was non-certified as there was limited documentation presented to suggest the injured worker required specialized cryotherapy over the use of cold packs as part of a home program or during the authorized physical therapy services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L4-5, L5-S1 microdiscectomy and hemilaminotomy, foraminotomy decompression:
Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Discectomy/Laminectomy.

Decision rationale: The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short-term and long-term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Guideline criteria have been met. This patient presents with severe function-limiting low back pain radiating down both legs. Clinical exam findings are consistent with imaging evidence of L4/5 and L5/S1 disc bulges and neuroforaminal narrowing with plausible nerve root compression. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Post operative cryotherapy 2x6: Upheld

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

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 hot or cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of at home hot or cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of specialized cryotherapy over standard ice packs at home or during physical therapy sessions as adjunctive care. Therefore, this request is not medically necessary.