

Case Number:	CM15-0077726		
Date Assigned:	04/29/2015	Date of Injury:	08/09/1988
Decision Date:	05/28/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/23/2015

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 64-year-old female who sustained an industrial injury on 8/09/88. The mechanism of injury was not documented. Past surgical history was positive for prior decompression surgery at L2/3, L3/4, and L5/S1 on 2/28/13. The 3/26/14 electrodiagnostic report documented bilateral S1 radiculopathy and mild right peroneal neuropathy in the calf. The 6/12/14 lumbar MRI documented a foraminal 3 mm disc osteophyte complex at L2/3, with mild involvement of the exiting right L3 nerve root. There was a right lateral disc protrusion at L2/3 with compromised exiting right L2 nerve root. There was evidence of minimal subluxation with L3 anterior to L2. The 3/23/15 treating physician report cited severe low back pain with lower extremity weakness and intermittent numbness. There was occasional severe numbness in the legs, feet, and buttocks. Physical exam documented diminished sensation of the left thigh and calf. The treatment plan included a right L2-3 microdiscectomy, motorized cold therapy rental x2 weeks for the lumbar spine, and a 2-3 day inpatient stay. The 3/31/15 utilization review certified the request for right L2-3 microdiscectomy. The associated request for a motorized cold therapy rental x2 weeks for the lumbar spine. The request for 2-3 day inpatient stay was modified to 1-d a y inpatient stay consistent with the Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient stay, 2-3 days: 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-TWC).

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 - Lumbar & Thoracic: Hospital length of stay (LOS).

Decision rationale: The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median practice target for lumbar discectomy is 1 day. The 3/31/15 utilization review modified the request for 2-3 days length of stay, certifying 1 day. There is no compelling reason to support the medical necessity beyond guideline recommendations and the 1 day hospital stay previously certified. Therefore, this request is not medically necessary.

Associated surgical service: Motorized cold therapy unit, 2 week rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC).

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. There is no compelling reason submitted to support the medical necessity of a cold therapy unit over standard cold packs and in the absence of guideline support. Therefore, this request is not medically necessary.