

Case Number:	CM14-0182075		
Date Assigned:	11/06/2014	Date of Injury:	09/15/2013
Decision Date:	10/02/2015	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/31/2014

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. 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:

This injured worker is a 31-year-old male who sustained an industrial injury on 9/15/13. Injury occurred relative to repetitive lifting, bending, stooping, and returning from bent and stooped positions in his job as an exterminator. Past medical history was positive for long-standing anxiety/depression and weekly psychotherapy treatment. Conservative treatment included lifestyle modifications, physical therapy, epidural steroid injections, and medications including anti-inflammatory medications, Valium, Lamictal, Pristiq, and Wellbutrin. A left L5/S1 diagnostic selective nerve root block provided 100% relief of pain that gradually returned in the 24 hours following the procedure. The 9/18/13 lumbar spine MRI documented a left sided 6-7 mm disc protrusion at L5/S1 with moderate left sided central canal narrowing and posterior displacement of the left S1 nerve root. The 7/29/14 lumbar spine x-rays documented disc space height loss at L4/5 and L5/S1. The 8/25/14 treating physician report cited constant grade 7-9/10 low back pain radiating into the left buttocks and down the posterior thigh. Physical exam documented antalgic gait, left lumbar paravertebral muscle tenderness, left upper buttock tenderness, restricted and painful lumbar range of motion, and positive left straight leg raise. The treatment plan included a left L5/S1 microdiscectomy. Authorization was also requested for a cold therapy unit with 30-day rental, deep vein thrombosis (DVT) unit with a 30-day rental, an assistant surgeon, pre-operative clearance, and an outpatient stay. The 10/1/14 utilization review certified the request for left L5/S1 microdiscectomy, and lumbosacral orthosis (LSO). The request for a cold therapy unit 30-day rental was modified to a 14-day rental as medically necessary and appropriate. The request for a 30-day rental of a DVT unit was non-certified as

there was no indication that the injured worker was at increased risk for DVT and early ambulation and activity would be expected immediately following this surgery. The request for an assistant surgeon was modified to a physician's assistant, nurse practitioner, or operating room tech, as the skills of a fully trained orthopedic surgeon were not clinically indicated. The request for pre-operative medical clearance was non-certified as there were no medical co-morbidities. The request for an outpatient stay was non-certified as there was no indication if the surgery was to be carried out as an outpatient or inpatient with overnight stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Low Back: Cold/heat packs.

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 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 a cold therapy unit in the absence of guideline support. Therefore, this request is not medically necessary.

Associated Surgical Service: DVT Unit (30-day rental): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Shoulder: Venous Thrombosis.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Venous Thrombosis.

Decision rationale: The California MTUS are silent with regard to deep vein thrombosis (DVT) prophylaxis. The Official Disability Guidelines (ODG) generally recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures, such as consideration for anticoagulation therapy. Guideline criteria have not been met. There are limited DVT risk factors identified for this patient. There is no documentation that anticoagulation therapy would be contraindicated, or standard compression stockings

insufficient, to warrant the use of mechanical prophylaxis. Therefore, this request is not medically necessary.

Associated Surgical Service: Assistant Surgeon: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

Decision rationale: The California MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures, which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT code 63030, there is a '2' in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

Preoperative Medical Clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.guideline.gov/content.aspx?id=38289>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have been met based on current anti-depressant and anti-epilepsy medication use and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Associated Surgical Service: Outpatient Stay: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): 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, 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 length of stay for lumbar discectomy is 1 day and best practice target is outpatient. This request for an outpatient stay is consistent with best practice target for length of stay. Therefore, this request is medically necessary.