

Case Number:	CM13-0024315		
Date Assigned:	02/26/2014	Date of Injury:	09/25/2011
Decision Date:	05/28/2014	UR Denial Date:	09/06/2013
Priority:	Standard	Application Received:	09/13/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

12/9/13 progress report indicates persistent low back pain radiating to the left lower extremity with numbness and tingling, constant severe pain, neck pain that radiates to the left greater than right upper extremities, and bilateral shoulder pain. Physical exam demonstrates lumbar tenderness, positive straight leg raise test, dysesthesia at the L5 and S1 dermatomes. 8/12/13 medical report discusses that the patient has stated all conservative measures, including activity modification, physical therapy, and pain management. Discussion identifies the patient has significant lumbar spondylosis from the levels of L1 to S1, most pronounced in the distal lumbar segments with significant Modic end plate changes. There is significant neural compromise. There is progressive neurologic deficit in the bilateral lower extremities with dragging feet and giving way of the legs. Treatment to date has included medication, injections, physical therapy, and chiropractic care. The patient has undergone previous left knee arthroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 POSSIBLE L3-4 POSTERIOR LUMBAR INTERBODY FUSION WITH INSTRUMENTATION, NEURAL DECOMPRESSION, AND ILIAC CREST MARROW ASPIRATION/HARVESTING, POSSIBLE JUNCTIONAL LEVELS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 305-307..

Decision rationale: CA MTUS states that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair; and failure of conservative treatment. In addition, CA MTUS states that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. The patient present with reported significant lumbar spondylosis from the levels of L1 to S1, most pronounced in the distal lumbar segments with significant Modic end plate changes. There is significant neural compromise. There is progressive neurologic deficit in the bilateral lower extremities with dragging feet and giving way of the legs. Treatment to date has included medication, injections, physical therapy, and chiropractic care. However, the formal MRI report was not made available for review. Flexion-extension X-ray reports were not provided either. The patient has not undergone psychological clearance for the proposed procedure. There is no evidence of dynamic segment instability or degenerative spondylolisthesis that would warrant the associated fusion procedure. Lastly the requested procedure was previously partially certified on 9/6/13; it is unclear why the patient did not undergo the intervention as previously provided for. Therefore, the request is not medically necessary.

" Associated surgical service"- ICE UNIT PURCHASE: 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.

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 CHAPTER, CONTINUOUS FLOW CRYOTHERAPY.

Decision rationale: CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, ODG does not provide indications for purchase of ice units. The associated request for surgery was not considered medically necessary. As such, the request for an Ice Unit purchase is also not medically necessary.

"Associated surgical service"- 3-1 COMMODE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment (DME).

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 CHAPTER, DURABLE MEDICAL EQUIPMENT.

Decision rationale: CA MTUS does not address this issue. ODG states that raised toilet seats are indicated as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. The associated request for surgery was not considered medically necessary. The specific functional limitations that would be anticipated were not clearly outlined. As such, the request for a 3-in-1 commode is also not medically necessary.