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| Case Number: | CM13-0025976 | | |
| Date Assigned: | 11/22/2013 | Date of Injury: | 07/18/2011 |
| Decision Date: | 05/16/2014 | UR Denial Date: | 08/23/2013 |
| Priority: | Standard | Application Received: | 09/19/2013 |

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 Orthopedic Surgery, has a subspecialty in Spine Surgery 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:

The injured worker is a 43-year-old female who reported injury on 07/18/2011. The mechanism of injury was a slip and fall in water. The documentation of 06/03/2013 revealed the injured worker had complaints of low back pain radiating to her legs with weakness and tingling in the lower extremities. It was indicated the injured worker had not responded to conservative care, including physical therapy, chiropractic care, acupuncture, bracing, and anti-inflammatory medications and epidural injections. The physical examination revealed the injured worker had paraspinal musculature tenderness, decreased range of motion and weakness, as well as decreased sensation in the lower extremities, consistent with disc degeneration, protrusion, and nerve root impingement that was shown on MRI. The office note further indicated the injured worker had an MRI of the lumbar spine on 11/19/2012, which demonstrated disc desiccation and diminished disc height at L5-S1 and a 3 mm to 4 mm posterior disc bulge and bilateral facet arthropathy. The diagnosis was lumbar disc protrusion. The request and treatment plan included an anterior and posterior discectomy, decompression, and fusion with instrumentation of the lumbar spine, as well as a medical clearance and 6 weeks to 12 weeks of physical therapy post-operatively.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 ANTERIOR POSTERIOR DISCECTOMY, DECOMPRESSION AND FUSION FOR THE LUMBAR SPINE: 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): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Discectomy, and Fusion

Decision rationale: ACOEM Guidelines indicate that direct methods of nerve decompression include laminotomy, standard discectomy, and laminectomy. The further indicate that spinal fusion is not recommended except for cases of trauma related spinal fracture or dislocation during the first 3 months of symptoms. Patients with increased spinal instability not work related after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. However, there was a lack of specific guidelines for the surgery. As such, secondary guidelines were sought. Official Disability Guidelines indicate that discectomies are recommended when patients have objective findings and symptoms to confirm the presence of radiculopathy. There should be documentation of a straight leg raise test, cross leg raising, and reflex examinations correlating with symptoms and imaging. At the level of L5, there should be severe unilateral foot/toe/dorsiflexor weakness/mild atrophy or mild to moderate foot/toe/dorsiflexor weakness or unilateral hip/lateral thigh/knee pain. At the level of the S1, there should be documentation of severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy, or moderate unilateral foot/toe/plantar flexor/hamstring weakness, or unilateral buttock/posterior thigh/calf pain. The injured worker should have imaging studies including an MRI. There should be documentation of nerve root compression upon objective examination. There should be documentation that conservative treatment, including activity modification, and (NSAID) non-steroidal anti-inflammatory drugs drug therapy, or other analgesic therapy, or muscle relaxants, or epidural steroid injection, and physical therapy or manual therapy or psychological screening. The clinical documentation submitted for review indicated the injured worker had epidural steroid injections and physical therapy. The objective physical examination indicated the injured worker had decreased sensation in the lower extremities consistent with disc degeneration, protrusion, and nerve root impingement shown on MRI. However, there was a lack of specific myotomal or dermatomal findings to support the requested levels. The request for a discectomy and decompression would not be medically necessary. Official Disability Guidelines indicate a spinal fusion is not recommended for patients who have less than 6 months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. It is recommended as an option for spinal fracture, dislocation, spondylolisthesis, or frank neurogenic compromise subject to selection criteria. Indications for a spinal fusion may include neural arch defect, segmental instability that is objectively demonstrable, primary mechanical pain, or revision surgery of a failed previous operation. The pre-surgical indications include all of the following: all pain generators are identified and treated, all physical medicine and manual therapies are completed, x-rays demonstrating spinal instability and/or myelogram, CT myelogram, or discography, and MRI disc pathology correlated with symptoms and exam findings, and spine pathology is limited to 2 levels, and there has been a psychosocial screen with confounding issues addressed. The clinical documentation submitted for review failed to indicate the injured worker had x-rays or objective examination demonstrating spinal instability, and there was no official MRI submitted for review. There was a lack of documentation indicating the injured worker had a psychosocial screening. The request for the fusion would not be supported. Given the above, the request for L5-S1 anterior posterior discectomy, decompression and fusion for the lumbar spine is not medically necessary.

2. 12 POST-OPERATIVE PHYSICAL THERAPY VISITS FOR THE LUMBAR SPINE IS NOT MEDICALLY NECESSARY AND APPROPRIATE.

The Claims Administrator based its decision on, since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

3. BONE GROWTH STIMULATOR UNKNOWN LENGTH IS NOT MEDICALLY NECESSARY AND APPROPRIATE.

The Claims Administrator based its decision on, since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

4. LSO BRACE IS NOT MEDICALLY NECESSARY AND APPROPRIATE.

The Claims Administrator based its decision on, since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

5. COLD THERAPY UNIT WITH PAD FOR 14 DAY RENTAL IS NOT MEDICALLY NECESSARY AND APPROPRIATE.

The Claims Administrator based its decision on, since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

BONE GROWHT STIMULATOR UNKNOWN LENGTH: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

LSO BRACE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

COLD THERAPY UNIT WITH PAD FOR 14 DAY RENTAL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.