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| Case Number: | CM13-0036136 | | |
| Date Assigned: | 12/13/2013 | Date of Injury: | 08/02/2006 |
| Decision Date: | 02/03/2014 | UR Denial Date: | 09/24/2013 |
| Priority: | Standard | Application Received: | 10/18/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedics and is licensed to practice in New Hampshire, New York, and Washington. 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 physician 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 patient is an adult female with the date of injury of August 2, 2006. She has chronic low back pain and has been diagnosed with lumbar segmental instability with chronic low back pain. Treatment has included activity modification, physical therapy, pain management, and 2 lumbar epidural blocks. Patient continues to have pain. Physical examination noted generalized weakness in the L4-5 and L5-S1 nerve roots and dermatomes. Was produced with flexion extension and there was a limited range of back motion. X-rays noted segmental instability at L4-5 but did not document specific movement of the L4-5 segment. Patient has chronic back pain and reports failing the affirmation conservative measures. At issue is whether additional surgical intervention is necessary at this time. Patient had a second lumbar epidural steroid injection which decreased pain by 50%. Another physical examination noted the patient had a normal gait. The patient had difficulty walking on the heels due to pain. Atrophy was present in the quadriceps. Back range of motion was limited. There was a normal lower extremity deep tendon reflexes were absent at the knees. Sensation was decreased on the right lateral thigh. Motor strength in the bilateral lower extremities was normal. MRI from October 2011 revealed 6 mm spondylolisthesis with encroachment of the cal sac and neuroforaminal narrowing at L4-5. At L5 S1- there is a 2 millimeter of posterior bone with encroachment on the right neuroforamen.

IMR ISSUES, DECISIONS AND RATIONALES

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

The L3 to L5 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 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 3-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter.

Decision rationale: The Physician Reviewer's decision rationale: This patient does not meet establish criteria for L3-L5 decompressive and fusion surgery. Specifically, abnormal motion and instability at the L4-5 segment is not clearly documented on the imaging studies. A report indicating the radiologist's interpretation of abnormal motion is not in the chart. Flexion-extension views demonstrating abnormal motion is not in the chart. Additionally the MRI imaging study is over 2 years old and does not show very severe spinal stenosis. In addition, the physical examination does not clearly documented specific lumbar radiculopathy that is correlated with a recent lumbar imaging study. The patient does not meet establish criteria for lumbar decompressive or fusion surgery at this time. The patient has no red flag indicators for spinal surgery to include concern for fracture, tumor, or progressive neurologic deficit. Established spinal surgery guidelines are not met.

Inpatient stay x 3 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 3-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter.

Decision rationale: The Physician Reviewer's decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Assistant Surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 3-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter.

Decision rationale: The Physician Reviewer's decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Medical clearance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 3-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter.

Decision rationale: The Physician Reviewer's decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Ice unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 3-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter.

Decision rationale: The Physician Reviewer's decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Front wheel walker: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 3-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter.

Decision rationale: The Physician Reviewer's decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Bone stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 3-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter.

Decision rationale: The Physician Reviewer's decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

TLSO (Thoracolumbosacral orthosis): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 3 Initial Approaches to Treatment Page(s): 3-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304+309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter.

Decision rationale: The Physician Reviewer's decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 3-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter.

Decision rationale: The Physician Reviewer's decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Alprazolam extended release tablet 1mg; one QHS #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 3-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter.

Decision rationale: The Physician Reviewer's decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Ondansetron ODT tablets 4 or 8mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 3-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

Decision rationale: The Physician Reviewer's decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.