

Case Number:	CM13-0041256		
Date Assigned:	12/20/2013	Date of Injury:	03/16/2011
Decision Date:	09/04/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	10/11/2013

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 and is licensed to practice in Maryland. 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:

This claimant is a 44-year-old gentleman injured on March 16, 2013. The clinical records for review document an injury to the low back. A clinical progress report dated September 24, 2013, notes an intermittent history of ongoing low back and radiating left leg pain. The note states that the claimant failed conservative care. Physical examination findings demonstrated tenderness to palpation of the lumbar spine musculature with restricted range of motion, weakness to the EHL, gastrocnemius and peroneal musculature of the left lower extremity. Left-sided straight leg raise test was positive. A September 16, 2013, MRI scan of the lumbar spine showed changes from prior laminectomy and discectomy at the L5-S1 level and no evidence of recurrent disc herniation. The records contained no documentation of other imaging. This request is for: a repeat lumbar discectomy with interbody fusion at the L5-S1 level; preoperative medical clearance; a three- to four-day inpatient hospital stay; 12 sessions of post-operative physical therapy; the post-operative use of a cold therapy unit; the post-operative use of a lumbar back brace; the post-operative use of a front-wheeled walker; the post-operative use of a bone stimulator; the post-operative use of a three-in-one commode; and the post-operative use of a shower chair.

IMR ISSUES, DECISIONS AND RATIONALES

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

REPEAT LUMBAR LAMINECTOMY AND DISC EXCISION, COMPLETE FACETECTOMY AND TRANSFORAMINAL INTERBODY FUSION @ L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: Based on California MTUS ACOEM Guidelines, a lumbar fusion at the L5-S1 level would not be indicated. Under ACOEM Guidelines, lumbar fusion can be indicated for individuals with significant segmental instability and progressive neurologic dysfunction. In this case, the claimant's recent MRI scan shows no compressive pathology or segmental instability to support the role of an L5-S1 fusion. Given the imaging results, there is no clinical correlation between the requested surgery and objective examination findings. Therefore, this request would not be established as medically necessary.

PRE-OP MEDICAL CLEARANCE WITH LABS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Chapter 7 Independent Medical Examinations and Consultations, page 127.

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

3-4 DAYS IN PATIENT STAY: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: low back procedure - Fusion (spinal) Hospital length of stay (LOS).

Decision rationale: The request for a lumbar fusion at the L5-S1 level is not established as medically necessary. Therefore, this request for a three- to four-day inpatient stay is not medically necessary.

POST OP PHYSICAL THERAPY TIMES 12: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

COLD THERAPY UNIT: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-339.

Decision rationale: The request for a lumbar fusion at the L5-S1 level is not established as medically necessary. Therefore, this request for the postoperative use of a cold therapy unit is not medically necessary.

SLEEP BACK BRACE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 9.

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: knee procedure - Walking aids (canes, crutches, braces, orthoses, & walkers).

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

BONE STIM: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in

Worker's Comp, 18th Edition, 2013 Updates: low back procedure -Bone growth stimulators (BGS).

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

3-IN-1 COMMODE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: knee procedure -Durable medical equipment (DME).

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

SHOWER CHAIR: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: knee procedure -Durable medical equipment (DME).

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