

Case Number:	CM13-0048444		
Date Assigned:	12/27/2013	Date of Injury:	05/03/2013
Decision Date:	03/06/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/05/2013

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 Orthopedic 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 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 a 55-year-old male who reported an injury on 05/03/2013 due to repetitive trauma while performing normal job duties. The patient reportedly sustained an injury to the low back, right ankle, and right shoulder. The patient underwent an MRI in 06/2013 that revealed there was a posterior disc bulge impinging on the L5-S1 exiting nerve roots, and a disc bulge at the L4-5 impinging on the left exiting L5 nerve root. The patient underwent an electrodiagnostic study in 07/2013 that did not reveal any acute lumbar radiculopathy. It was noted that the patient had an acute exacerbation of chronic low back pain in 05/2013. Treatments for this exacerbation have been physical therapy, activity modifications, and medications. The patient's most recent clinical examination revealed tenderness to palpation along the lumbar paravertebral musculature, with pain with range of motion, and a positive straight leg raising test with a disturbed sensation in the L5 and S1 dermatomes. The patient's diagnoses included cervical/lumbar discopathy, right shoulder impingement, and sprain/strain of the right ankle. A fusion at the L5-S1 with possible fusion at the L4 and L5 was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 possible L4-L5 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC, Low Back Procedure Summary, updated 10/09/2013.

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, Fusion (spinal).

Decision rationale: The requested L5-S1 possible L4-5 lumbar interbody fusion with instrumentation neural decompression and iliac crest marrow aspiration/harvesting possible junctional levels is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not recommend spinal fusion in the absence of documented instability or trauma-related fracture or dislocation. The clinical documentation submitted for review does not provide any evidence of spinal instability that would benefit from a fusion. Additionally, Official Disability Guidelines do not recommend spinal fusion unless all conservative and surgical interventions have been exhausted. The clinical documentation submitted for review does not provide any evidence that the patient has had any other surgical intervention for this injury. Additionally, the clinical documentation submitted for review does indicate that the patient has had physical therapy and medications; however, there is no documentation that the patient has failed to respond to epidural steroid injections for this acute exacerbation. Although there is evidence that the patient has neurological compromise, he may benefit from further conservative therapy and surgical intervention; all lesser levels of treatment have not been exhausted. Therefore, fusion would not be supported at this time. Additionally, the clinical documentation submitted for review did not include a psychological evaluation that determined the patient was a good candidate for this type of surgery. As such, the requested L5-S1 possible L4-5 lumbar interbody fusion with instrumentation neural decompression and iliac crest marrow aspiration/harvesting possible junctional levels is not medically necessary or appropriate.

Ice Unit Purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Low Back Procedure Summary, updated 10/09/2013.

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.

Decision rationale: The requested ice unit for purchase is not medically necessary or appropriate. Official Disability Guidelines recommend a continuous flow cryotherapy unit for up to 7 days after surgical intervention. Therefore, the purchase of a unit would not be supported. Additionally, the requested surgical intervention is not supported at this time. As such, the requested ice unit for purchase is not medically necessary or appropriate.

TLSO purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, updated 5/10/2013.

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 Chapter, Back brace, post operative (fusion).

Decision rationale: The requested TLSO brace is not medically necessary or appropriate. Official Disability Guidelines do not recommend postsurgical bracing after fusion surgery. Additionally, the requested surgery is not supported by the submitted documentation. As such, the requested TLSO for purchase is not medically necessary or appropriate.