

Case Number:	CM14-0001683		
Date Assigned:	01/22/2014	Date of Injury:	02/05/2012
Decision Date:	06/19/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	01/06/2014

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 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 51-year-old male who reported an injury on 02/05/2012 after lifting some boxes that reportedly caused an injury to his low back. The injured worker underwent an MRI on 04/12/2013 that noted there was a disc bulge at the L4-5 abutting the right L5 nerve root and a disc bulge at the L5-S1 compressing the left S1 nerve root. The injured worker's treatment history included an epidural steroid injection. The injured worker was evaluated on 12/09/2013. It was documented that the injured worker had limited range of motion secondary to pain. It was noted that the injured worker had no new motor strength deficits or sensory deficits. The injured worker's diagnoses included left shoulder rotator cuff tear and disc herniation of the lumbar spine. The injured worker's treatment plan included fusion surgery from the L3-S1 followed by postoperative care.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR DECOMPRESSION INCLUDING LAMINECTOMY, DISCECTOMY, FACETECTOMY, FORAMINOTOMY AT L3-S1 FUSION WITH ILIAC CREST BONE GRAFT & INSTRUMENTATION INCLUDING CAGES & PEDICLE SCREWS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, CHAPTER 12 LOW BACK COMPLAINTS,

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 lumbar decompression including laminectomy, discectomy, facetectomy, foraminotomy at the L3-S1 fusion with iliac crest bone graft and instrumentation including cages and pedicle screws is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends spinal fusion of the lumbar spine when there is evidence of significant instability or vertebral trauma. The clinical documentation submitted for review does indicate that the injured worker has an imaging study that supports nerve root impingement. However, the injured worker's most recent clinical documentation did not provide significant evidence of radicular findings. There was no motor strength weakness or disturbed sensation in the L3-S1 dermatomal distributions. Additionally, there was no documentation of a straight leg raising test to support radicular pain. Furthermore, the clinical documentation submitted for review fails to identify whether the injured worker has previously participated in any type of active therapy to address pain complaints. Official Disability Guidelines also recommend that injured workers undergo a psychological assessment prior to multilevel fusion surgery. The clinical documentation submitted for review does not provide any evidence that the injured worker has undergone a psychological consultation to determine the appropriateness of this surgical intervention. As such, the requested lumbar decompression include laminectomy, discectomy, facetectomy, foraminotomy at the L3-S1 fusion with iliac crest bone grafts and instrumentation including cages and pedicle screws is not medically necessary or appropriate.

INPATIENT STAY TWO (2) TO THREE (3) DAYS: 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.

MEDICAL CLEARANCE: 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.

INTRAOPERATIVE MONITORING SERVICE, SPINAL CORD SOMATOSENSORY EVOKED POTENTIAL (SSSEP) (UPPER AND LOWER EXTREMITIES), ELECTROMYOGRAM (EMG): 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: 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.

SX STIM / BONE: 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.

BACK 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.

3-1 COMMODE / 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 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.

PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS, POST-OP:
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.

LABORATORY EVALUATIONS FOR MEDICAL CLEARANCE: 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.

EKG FOR MEDICAL CLEARANCE: 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.

CHEST X-RAY FOR MEDICAL CLEARANCE: 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.

