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| Case Number: | CM14-0106041 | | |
| Date Assigned: | 08/06/2014 | Date of Injury: | 09/08/2008 |
| Decision Date: | 09/11/2014 | UR Denial Date: | 06/17/2014 |
| Priority: | Standard | Application Received: | 07/09/2014 |

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 claimant is a 57-year-old female who sustained a low-back injury in work-related accident on September 8, 2008. The records provided for review include an April 3, 2014, MRI report showing level L3-4 neuroforaminal narrowing without evidence of compressive pathology, as well as L4-5 and L5-S1 disc protrusion. This pathology has resulted in mild to moderate neural canal narrowing with no evidence of definitive exiting nerve root effacement. There is no documentation of instability at any lumbar level. A May 6, 2014, follow-up report describes continued low back and radiating bilateral leg pain. Physical examination findings include some left leg weakness with no specific dermatomal distribution. The records state that the claimant has been treated with medication management, epidural steroid injections, physical therapy and work restrictions. This request is for: a three-level L3-S1 lumbar fusion; PFS/PSI; an assistant surgeon; a postoperative, two-day inpatient hospital stay; the postoperative use of a lumbar brace; the use of an external bone growth stimulator postoperatively; 18 sessions of postoperative physical therapy; and one box of island bandages for postoperative use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Lumbar Interbody Fusion L3-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

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

Decision rationale: California MTUS ACOEM Guidelines would not support the role of a transforaminal lumbar interbody fusion of L3-S1. ACOEM Guidelines recommend surgery when there is evidence of spinal-related fracture, dislocation or segmental instability following prior decompression. The reviewed records in this case do not document segmental instability or specific nerve root compromise on imaging. Due to absence of these findings, the request for transforaminal lumbar interbody fusion L3-S1 would not be established as medically necessary.

PSF/PSI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

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

Decision rationale: California MTUS ACOEM Guidelines would not support the role of a transforaminal lumbar interbody fusion of L3-S1 or PSF or PSI. ACOEM Guidelines recommend fusion surgery when there is evidence of spinal-related fracture, dislocation or segmental instability following prior decompression. The reviewed records in this case do not document segmental instability or specific nerve root compromise on imaging. Due to absence of these findings, the request for a PSF/PSI would not be established as medically necessary.

Assistant Surgeon: 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 -Other Medical Treatment Guideline or Medical Evidence: Milliman Care Guidelines 18th edition: assistant surgeon.

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

2 Day Inpatient Stay: 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) Low Back Chapter).

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).

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

Lumbar Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 12 Low Back Complaints Page(s): 9,298, 301.

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

External Bone Growth Stimulator: 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) Neck And Upper Back Chapter.

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.

18 Sessions for Post Op Physical Therapy (3x for 6weeks): 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.

1 Box Island Bandages: 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; 2013 Updates; 18th Edition; Knee and Leg Chapter: DME

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