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| Case Number: | CM14-0108380 | | |
| Date Assigned: | 08/06/2014 | Date of Injury: | 06/14/2012 |
| Decision Date: | 09/26/2014 | UR Denial Date: | 06/25/2014 |
| Priority: | Standard | Application Received: | 07/11/2014 |

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 Spine Surgery, and is licensed to practice in Texas. 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 53-year-old female, who reported an injury on 06/14/2012. The mechanism of injury involved a fall. Current diagnoses include displaced lumbar intervertebral disc, degenerative lumbar or lumbosacral intervertebral discs, lumbar spinal stenosis, and unspecified thoracic/lumbosacral neuritis/radiculitis. The injured worker was evaluated on 02/08/2014 with complaints of persistent lower back pain with activity restriction. It is noted that the injured worker has been previously treated with physical therapy, medication management, and an SI joint injection. Physical examination was not provided on that date. Treatment recommendations at that time included a formal request for an L4-5 and L5-S1 posterior decompression and instrumented fusion. The current medication regimen includes Norco 10/325 mg, Norflex 100 mg, and naproxen 500 mg. It was also noted that the injured worker was participating in a home exercise program and was issued a recommendation for a gym membership for general health conditioning. There was Request for Authorization Form submitted for the current request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op Physical Therapy three times a week for three weeks for the Lumbar Spine: 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.

L4-L5 Laminectomy, Discectomy, any repairs: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation ACOEM 2009; Official Disability Guidelines treatment index 11th Edition 2013.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Discectomy/Laminectomy.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, clear clinical, imaging and electrophysiologic evidence of a lesion, and a failure of conservative treatment. The Official Disability Guidelines state prior to a discectomy/laminectomy, there should be objective evidence of radiculopathy. Imaging studies should reveal evidence of nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment should include activity modification, drug therapy, and epidural steroid injections. There should also be documentation of a referral to physical therapy, manual therapy, or the completion of a psychological screening. There is no documentation of radiculopathy upon physical examination on the requesting date. There is also no mention of an exhaustion of conservative treatment to include epidural steroid injection. There were also no imaging studies provided for this review. Based on the clinical information received and the above-mentioned guidelines, the request is not medically necessary.

Inpatient hospital stay for three 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.

EKG: 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: As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary. Therefore, the request is non-certified.

Chest X-ray: 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.

Pre-op Labs: 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.

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 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.

L5-S1 Posterior Interbody Decompressions, Fusion, Instrumentation, Allografting: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment Index 11th Edition (web) 2013 Fusion.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, Fusion (spinal).

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, clear clinical, imaging and electrophysiologic evidence of a lesion, and a failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology limited to 2 levels, and a psychosocial screening. As per the documentation submitted, there were no imaging studies provided for this review. There were no flexion/extension view radiographs provided with documentation of spinal instability. There is also no documentation of a psychosocial screening prior to the request for a lumbar fusion. Based on the clinical information received and the above-mentioned guidelines, the request is non-certified.

Back Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment Index, 11th Edition (web) 2013 Low Back Chapter.

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.