

Case Number:	CM14-0013414		
Date Assigned:	02/26/2014	Date of Injury:	05/28/2013
Decision Date:	07/11/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	02/03/2014

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, has a subspecialty in Spine 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 38-year-old male who reported an injury on 05/28/2013. The injured worker's treatment history included physical therapy, chiropractic therapy, pain management, epidural steroid injections, and activity modifications. The patient underwent an MRI on 07/26/2013 that documented there was a 4 mm disc bulge at the L5-S1 causing left foraminal narrowing and a 2 to 3 mm disc bulge at L4-5. The injured worker underwent a discogram on 12/09/2013 that was negative at the L3-4 and positive at the L4-5 with concordant severe pain at the L5-S1 and L4-5. The injured worker was evaluated on 12/06/2013. It was documented that the patient was a surgical candidate. Physical findings included continued pain complaints, resolved right lower extremity radiculopathy. The injured worker was again evaluated on 01/07/2014. The injured worker's treatment plan included L5-S1 fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 ANTERIOR LUMBER INTERBODY FUSION WITH CAGE AND INSTRUMENTATION, AND L5-S1 POSTERIOR LUMBAR INTERBODY FUSION AND RIGHT SIDED LAMINECTOMY: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 308-310.

Decision rationale: The requested L5-S1 anterior lumbar interbody fusion with cage and instrumentation and L5-S1 posterior interbody fusion and right sided laminectomy are not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends fusion surgery for patients who have evidence of instability that would benefit from a fusion procedure. The clinical documentation does not provide any evidence that the patient has evidence of instability that would require a fusion procedure. No documentation that the patient has failed to respond to lesser types of surgery. Furthermore, the injured worker's most recent clinical documentation dated 12/06/2013 and 01/07/2014 did not provide any physical findings of lower extremity radiculopathy in distributions consistent with the L5-S1 abnormalities identified on the imaging study. Therefore, surgical intervention would not be supported by guideline recommendations in this clinical situation. As such, the requested L5-S1 anterior lumbar interbody fusion with cage and instrumentation and L5-S1 posterior lumbar interbody fusion and right sided laminectomy are not medically necessary or appropriate. As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

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.

CO-VASCULAR 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.

3-DAY INPATIENT STAY: 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 (30 DAY RENTAL): 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.

LUMBAR SACRAL ORTHOSIS (LSO) 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.

PNEUMATIC INTERMITTENT COMPRESSION DEVICE: 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.

POSTOPERATIVE PHYSICAL THERAPY 3 TIMES PER WEEK FOR 6 WEEKS:

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.

PREOPERATIVE MEDICAL CLEARANCE AND 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.