

Case Number:	CM14-0019754		
Date Assigned:	04/28/2014	Date of Injury:	11/16/2011
Decision Date:	07/10/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/18/2014

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 Fellowship trained 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 50-year-old female who reported an injury on 11/16/2011. The mechanism of injury was not stated. Current diagnoses include displacement of lumbar intervertebral disc without myelopathy, lumbosacral spondylosis without myelopathy, and sciatica. The injured worker was evaluated on 01/31/2014. The injured worker reported severe low back pain with right lower extremity radiation. Physical examination revealed tenderness to palpation, severely decreased range of motion, positive tension sign on the right, decreased sensation at the top of the right foot and large toe, and a slightly antalgic gait. Treatment recommendations at that time included an anterior lumbar interbody fusion at L5-S1 with disc replacement at L4-5.

IMR ISSUES, DECISIONS AND RATIONALES

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

ANTERIOR LUMBAR INTERBODY FUSION AT L5-S1 WITH A TOTAL DISC ARTHROPLASTY AT L4-5: 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): 305-307.

Decision rationale: California MTUS/ACOEM Practice Guidelines state surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, extreme progression of lower extremity symptoms, clear clinical, imaging, and electrophysiological evidence of a lesion, and a failure of conservative treatment. Official Disability Guidelines state disc prosthesis is not recommended. Pre-operative clinical surgical indications for a spinal fusion should include identification and treatment of all pain generators, completion of all physical medicine and manual therapy interventions, demonstration of spinal instability upon x-ray and/or CT myelogram, and completion of a psychosocial screening. As per the documentation submitted, there is no mention of an exhaustion of conservative treatment prior to the request for a surgical intervention. There is no documentation of spinal instability upon flexion and extension view radiographs. There is also no evidence of the completion of a psychosocial screening. Based on the clinical information received, the request is not medically necessary.

APPROACH 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.

FIRST 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.

3-4 DAYS INPATIENT HOSPITAL 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.

INTRA-OPERATIVE NEUROPHYSIOLOGICAL MONITORING: 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 EKG/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.

PREOPERATIVE LABS (CBC, CMP, PT/PTT, & URINALYSIS), POSSIBLE 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.

LUMBAR 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..

COLD THERAPY VASCUTHERM 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.

INITIAL HOME HEALTH VISIT WITH 1 OR 2 VISITS FOR SKILLED OBSERVATION OF INCISION HEALING, PAIN MANAGEMENT, NEUROLOGICAL STATUS, HOME SAFETY AND EQUIPMENT NEEDS: 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.

12 POST-OPERATIVE PHYSICAL THERAPY SESSIONS: 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.