

Case Number:	CM14-0115373		
Date Assigned:	08/06/2014	Date of Injury:	07/24/2013
Decision Date:	09/10/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/23/2014

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 Neurological 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 records presented for review indicate that this 47 year-old individual was reportedly injured on July 24, 2013. The mechanism of injury was not listed in the records received. The most recent progress note, dated June 10, 2014, indicated that there were ongoing complaints of low back pain, increased pain with fatigue, right shoulder pain, and right leg pain. The physical examination demonstrated an unchanged assessment of the right shoulder, a decreased range of motion in the lumbar spine, and manual muscle testing was noted to be 4/5. The right leg was noted no relief with the injections performed. Diagnostic imaging studies reportedly noted a slap tear in the right shoulder, a tendinosis in the right shoulder and a disc protrusion in the lumbar spine. Previous treatment included physical therapy, multiple medications, and pain management interventions. A request had been made for surgical intervention and was not certified in the pre-authorization process on June 30, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior /Posterior Lumbar Disectomy, Decompression, and Fusion w/Instrumentation, Allograft and Bone Morphogenic Protein at the levels of L4-L5.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Section for the Low Back under the heading for Patient Selection Criteria for Fusion.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: Based on the clinical records presented for review, there is no evidence of a fracture, dislocation, tumor or infection. Therefore, a lumbar fusion procedure is not recommended. Furthermore, there is no objectification of a verifiable radiculopathy that would warrant such an endeavor. Therefore, based on the clinical information presented in the progress notes and with the parameters noted in the ACOEM guidelines, the medical evidence to conduct the surgery is not present and is not medically necessary.

Pre-Op Medical Clearance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Preoperative Evaluation Am Fam Physician. 2000 Jul 15; 62(2):387-396.

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

Post Op Lumbar Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Post Op Physical Therapy x12: Upheld

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

Post Op. Cold Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Cryo Therapies.

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

Bone Stimulation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back C.

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