

Case Number:	CM14-0125160		
Date Assigned:	08/11/2014	Date of Injury:	12/23/1995
Decision Date:	09/15/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	08/07/2014

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 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 48 year old male who reported an injury to his low back. The clinical note dated 07/25/14 indicates the injured worker presenting with low back pain. The injured worker stated he was having difficulty with completing his activities of daily living. The injured worker described the pain as constant and achy. Radiating pain was identified from the low back into the right lower extremity. The note indicates the injured worker having no sensation, strength, or reflex deficits at that time. The clinical note dated 07/18/14 indicates the initial injury occurred when he was involved in a motor vehicle accident. The injured worker stated that he had been rear-ended. The injured worker rated the pain as 6-10/10 at that time. There is an indication the injured worker has undergone a magnetic resonance image which revealed a previous laminectomy at L4 and L5. The injured worker was being recommended for a laminectomy and fusion at that time at the L4-5 level. The clinical note dated 06/18/14 indicates the injured worker showing no reflex, strength or sensation deficits. The injured worker was able to demonstrate 10 degrees of both flexion and extension at that time. X-rays of the lumbar spine dated 04/30/14 revealed the injured worker having no instability in the lumbar region. There is a possibility of severe degenerative disc disease at the L4-5 level. The magnetic resonance image of the lumbar spine dated 05/20/14 revealed post-laminectomy changes at L4-5. A 4mm posterior disc osteophyte complex was identified.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 Lateral Interbody Discectomy/Fusion, and Posterior Revision Laminectomy and Fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines-Indications for Surgery-Discectomy/Laminectomy, Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The documentation indicates the injured worker complaining of ongoing low back pain. A laminectomy and fusion is indicated in the lumbar region provided the injured worker meets specific criteria to include completion of all conservative treatments and the injured worker's clinical exam findings correlate with the injured worker's imaging studies. The magnetic resonance image revealed significant findings at the L4-5 level. No strength, reflex or sensation deficits were identified in the L4 or L5 distributions. No information was submitted regarding the completion of any conservative treatments addressing the lumbar region complaints as no therapy or procedural notes were submitted confirming the injured worker's completion of a full course of therapeutic interventions or injection therapy. Additionally, no information was submitted regarding the injured worker's instability confirmed by x-rays or the completion of a psychosocial screening. Given these factors, the request for L4-5 Lateral Interbody Discectomy/Fusion, and Posterior Revision Laminectomy and Fusion is not medically necessary.

Assistant Surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Musculoskeletal System Surgery The Centers for Medicare & Medicaid.

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: 1.) American Association of Orthopaedics Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics <http://www.aaos.org/about/papers/position/1120.asp>.

Decision rationale: Given the non-certification of the surgery, the additional request for preoperative and postoperative treatments (Assistant Surgeon) is rendered not medically necessary.

Pre-op Medical Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule (1999), pages 92-93.

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 Chapter, Preoperative testing, general.

Decision rationale: Given the non-certification of the surgery, the additional request for preoperative and postoperative treatments (Pre-Operative Medical Clearance) is rendered not medically necessary.

3-4 Days In-Patient 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-Hospital Length of Stay (LOS) Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hospital length of stay (LOS).

Decision rationale: Given the non-certification of the surgery, the additional request for preoperative and postoperative treatments (3-4 Days In-Patient Stay) is rendered not medically necessary.

Reclining Chair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Durable Medical Equipment.

Decision rationale: Given the non-certification of the surgery, the additional request for preoperative and postoperative treatments (Reclining Chair) is rendered not medically necessary.

Back Brace or Cervical Collar: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175, 301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back-Lumbar & Thoracic (Acute & Chronic), Neck & Upper Back (Acute & Chronic).

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 Chapter, Lumbar Supports.

Decision rationale: Given the non-certification of the surgery, the additional request for preoperative and postoperative treatments (Back Brace or Cervical Collar) is rendered not medically necessary.

NMES /TENS Unit with Garment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NMES Devices & TENS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: Given the non-certification of the surgery, the additional request for preoperative and postoperative treatments (NMES /TENS Unit with Garment) is rendered not medically necessary.