

Case Number:	CM14-0156781		
Date Assigned:	09/26/2014	Date of Injury:	01/12/2010
Decision Date:	10/28/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	09/23/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine, 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 55-year-old male who reported an injury on 01/12/2010 due to an unknown mechanism. Diagnoses were lumbar discogenic disease with radiculopathy, chronic low back pain, lumbar facet arthropathy, cervical discogenic disease, chronic cervical spine sprain/strain, history of umbilical hernia of industrial causation. Past treatments were not reported. Diagnostic studies of the cervical spine on 06/27/2014 revealed C4-5, focal central disc protrusion effacing the thecal sac and spinal cord. C5 exiting nerve roots were unremarkable. C5-6 diffuse disc protrusion effacing the thecal sac. Bilateral neural foraminal narrowing that effaces the left and right C6 exiting nerve roots. Disc measurements: Extension was 3.1 mm. C6-7 revealed diffuse disc protrusion effacing the thecal sac. C7 exiting nerve root was unremarkable. Grade 1 retrolisthesis of the C5 over C6 noted. MRI of the lumbar spine dated 06/27/2014 revealed disc desiccation noted at the L2-3, L3-4, and L4-5 levels. At the L2-3, there was focal central disc extrusion with inferior migration superimposed on diffuse disc bulge and annular tear indenting the thecal sac. Disc material and facet hypertrophy caused bilateral neural foraminal stenosis that encroached the left and right L2 exiting nerve roots. L3-4 revealed diffuse disc protrusion compressing the thecal sac. Disc material and facet hypertrophy caused by lateral neural foraminal stenosis that encroached the left and right L3 exiting nerve roots. Posterior spinal elements were deficient at the L4-5 and L5-S1 levels, correlate with surgical history. Physical examination on 08/14/2014 revealed complaints of low back pain rated 10/10, cervical spine pain rated a 10/10. Examination of the lumbar spine revealed spasm, painful range of motion, as well as limited range of motion. Positive Lasegue bilaterally. Positive straight leg raising on the right at 60 degrees and on the left at 50 degrees, and motor weakness in quads bilaterally at 4/5. Pain bilaterally at S1 distribution. Sensation was intact. Cervical spine examination revealed spasm, pain, and decreased range of motion. There was facet tenderness.

Hoffman sign was positive. There was radiculopathy bilaterally at C5 and C6, and tenderness to palpation over the cervicotrachezial ridge. Motor weakness was 4/5 bilaterally. Medications were Norco, gabapentin. Treatment plan was for fusion of the lumbar L2-5. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op purchase of 3 in 1 commode: 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 requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

Post-op purchase of a 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: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

Post-op purchase of a front wheeled walker: 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 requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

Post-op home health aid 4 hours per day 5 days per week for 2 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: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

Post-op home health evaluation for medication management and to ensure the patient is on a home exercise program: 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 requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

Consult with vascular surgeon: 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 (ODG), Low Back, Fusion

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), 2nd Edition, (2004) Chapter 6, page 163, Low Back Complaints, Surgical Considerations, page 305-306

Decision rationale: The decision for consult with vascular surgeon is not medically necessary. The American College of Occupational and Environmental Medicine Guidelines state that a consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, determination of medical stability and permanent residual loss and/or examine his fitness for return to work. There was no clear rationale to support the consultation. The guidelines also state for surgical considerations within the first 3 months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy is detected. Surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than 1 month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and especially expectations is very important. Patients with acute low back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may help resolve the symptoms. Before referral for surgery, clinicians should consider a referral for psychological screening to improve surgical outcomes, possibly including standard tests such as the second edition of the Minnesota Multiphasic

Personality Inventory (MMPI 2). In addition, clinicians may look for Waddell signs during the physical exam. Many patients with strong clinical findings of nerve root dysfunction due to disc herniation recover activity tolerance within 1 month. There is no evidence that delaying the surgery for this period worsens outcomes in the absence of progressive nerve root compromise. With or without surgery, more than 80% of patients with apparent surgical indications eventually recover. There were no objective functional improvement reports from the injured worker participating in physical therapy, acupuncture, chiropractic sessions or a home exercise program. It was not reported that conservative therapy had failed. There were no recent reports of current physical therapy for the injured worker. The clinical information submitted for review does not provide evidence to justify a consult with a vascular surgeon. Therefore, this request is not medically necessary.

Vascular co-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: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.