

Case Number:	CM14-0167453		
Date Assigned:	10/28/2014	Date of Injury:	02/02/2011
Decision Date:	12/04/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/10/2014

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 Spine Surgeon 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 32-year-old female who reported an injury on 02/02/2011. The injured worker was reportedly pushed into a wall. The current diagnoses include left C7 radiculopathy, left shoulder impingement syndrome, L4-5 annular tear, L5 lytic grade I spondylolisthesis, and left leg radiculopathy. The injured worker was evaluated on 08/27/2014 with complaints of persistent lower back pain with numbness radiating into the buttock region and down the left lower extremity. The current medication regimen includes naproxen 500 mg and Protonix 20 mg. Previous conservative treatment includes NSAIDs, physical therapy, epidural steroid injection, and activity modification. Physical examination of the lumbar spine revealed a normal gait, no evidence of weakness with walking, palpable tenderness over the midline lumbar spine, left sacroiliac joint tenderness, left greater trochanter tenderness, left anterior hip joint tenderness, restricted sensation in the left L3-S1 dermatomal distributions, 28 degree flexion, 10 degree extension, 10 degree left lateral bending, 8 degree right lateral bending, absent reflexes in the left lower extremity, and diminished extensor hallucis longus strength. Treatment recommendations at that time included an L5 laminectomy and L5-S1 posterior fusion. Postoperative durable medical equipment, postoperative physical therapy, and preoperative medical clearance were also requested on that date. A Request for Authorization form was then submitted on 08/27/2014. It is noted that the injured worker underwent an electrodiagnostic study on 05/13/2014, which indicated evidence of left distal peroneal neuropathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5 GIL Laminectomy, and L5-S1 posterior fusion and L5-S1 TLIF: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (Spinal)

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, clear clinical, imaging, and electrophysiological evidence of a lesion, and failure of conservative treatment. Direct methods of nerve root decompression include laminotomy, standard discectomy, and laminectomy. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. As per the documentation submitted, the injured worker has exhausted conservative treatment. However, there is no documentation of spinal instability upon flexion and extension view radiographs. There was no imaging studies provided for this review. There is no documentation of a psychosocial screening prior to the request for a lumbar fusion. Based on the clinical information received, the injured worker does not meet criteria for the requested procedure. As such, the request is not medically appropriate at this time.

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.

Front Wheel 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: 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.

Post-Op physiotherapy, 3 times a 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.

Pre-Op 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.

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.

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.

2 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.