

Case Number:	CM14-0023693		
Date Assigned:	06/11/2014	Date of Injury:	04/16/2008
Decision Date:	07/15/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	02/25/2014

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 subspecialty 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 48-year-old male who reported an injury on 04/16/2008. The mechanism of injury was not stated. Current diagnoses include bilateral chronic active L5-S1 radiculopathy, left knee ACL tear, L4-5 grade 1 spondylolisthesis, L4 to S1 disc degeneration, and greater trochanter bursitis in bilateral hips. The injured worker was evaluated on 01/15/2014 with complaints of low back pain radiating into the bilateral lower extremities. Current medications include Celebrex 200 mg. Physical examination revealed tenderness to palpation of the paravertebral muscles bilaterally, decreased sensation in the left lower extremity, limited lumbar range of motion, 5/5 motor strength, and 2+ deep tendon reflexes. Previous conservative treatment includes epidural steroid injection and physical therapy. Treatment recommendations at that time included an L4-5 and L5-S1 laminotomy and foraminotomy. It is noted that the injured worker underwent an MRI of the lumbar spine on 03/08/2012, which indicated a 5 mm grade 1 anterolisthesis at L4-5 with a 6 mm generalized disc bulge, and a 5 mm generalized disc bulge at L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5, L5-S1 LAMINOTOMY AND FORAMINOTOMY: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

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, Laminectomy/ laminotomy.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a surgical consultation may be indicated for patients who have severe and disabling lower extremity symptoms, extreme progression of symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion, and a failure of conservative treatment. The Official Disability Guidelines state laminectomy and laminotomy are recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement. As per the documentation submitted, the injured worker's MRI of the lumbar spine does reveal a 5 mm grade 1 anterolisthesis at L4-5, partial disc desiccation and disc bulge, facet arthropathy, severe right sided and moderate to severe left sided stenosis, compression of the L5 nerve root, a 5 mm disc bulge at L5-S1, partial disc desiccation, facet arthropathy, mild bilateral neural foraminal narrowing, and encroachment on the descending S1 nerve root. The injured worker has been previously treated with epidural steroid injections and physical therapy. Based on the aforementioned points, the injured worker does currently meet criteria for the requested procedure. As such, the request for L4-L5, L5-S1 LAMINOTOMY AND FORAMINOTOMY is certified.

2 DAY INPATIENT STAY: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Hospital Length of Stay.

Decision rationale: The Official Disability Guidelines state following a laminectomy/laminotomy for decompression of the spinal nerve root, the hospital length of stay includes a median of 2 days. Therefore, the current request for a 2-day inpatient stay does fall within Guideline recommendations. As such, the request for 2 DAY INPATIENT STAY is certified

PRE-OP CLEARANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Preoperative Testing, General.

Decision rationale: The Official Disability Guidelines state preoperative testing is guided by the patient's clinical history, comorbidities, and physical examination findings. As per the documentation submitted, there is no evidence of a significant medical history or any

comorbidities that would warrant the need for a preoperative medical clearance. Therefore, the medical necessity has not been established. As such, the request for PRE-OP CLEARANCE is non-certified.

POSTOPERATIVE 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 base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg Chapter, Walking Aids.

Decision rationale: The Official Disability Guidelines state walking aids, such as walkers, are recommended for specific indications. There is no indication that this injured worker will require the use of an assistive device following surgical intervention. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request for POSTOPERATIVE FRONT-WHEELED WALKER is non-certified.

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 base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Back brace, post operative (fusion).

Decision rationale: The Official Disability Guidelines state a postoperative back brace is currently under study following a lumbar fusion. The injured worker is not currently scheduled to undergo a lumbar fusion. Therefore, the medical necessity for the requested durable medical equipment has not been established. As such, the request for LSO BRACE is non-certified.

POSTOPERATIVE PHYSICAL THERAPY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The California MTUS Guidelines state the initial course of therapy means one-half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations. Postsurgical treatment following a laminectomy includes 16 visits over 8 weeks. There is no specific frequency or quantity listed in the request. Therefore, the request for POSTOPERATIVE PHYSICAL THERAPY is non-certified.

PROTONIX 20MG 1 BY MOUTH TWICE DAILY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. There is also no quantity listed in the current request. Therefore, the request for PROTONIX 20MG 1 BY MOUTH TWICE DAILY is non-certified.