

Case Number:	CM14-0026665		
Date Assigned:	06/16/2014	Date of Injury:	08/26/2012
Decision Date:	07/24/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/03/2014

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 Orthopedic Sports Medicine 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 39 year old male who reported an injury to his low back. The clinical note dated 02/03/14 indicates the injured worker continuing with complaints of low back pain that was rated as 5/10. Radiating pain continued into the right buttocks. No sensation deficits were identified in the lower extremities. The injured worker demonstrated 5/5 strength throughout the lower extremities. The procedural note dated 02/18/13 indicates the injured worker having undergone a radiofrequency neurolysis bilaterally at L5-S1. The clinical note dated 08/26/13 indicates the injured worker complaining of lumbar region pain. The note indicates the injured worker utilizing cyclobenzaprine, dexamethasone, hydrocodone, and naproxen for pain relief. Upon exam, the injured worker was able to demonstrate normal ambulation with heel and swing through gait with no evidence of a limp. Tenderness was identified upon palpation at the paravertebral musculature bilaterally. The injured worker was able to demonstrate 32 degrees of lumbar flexion, 8 degrees of extension, 22 degrees of left lateral bending, and 20 degrees of right lateral bending. No strength or reflex deficits were identified in the lower extremities. The procedural note dated 10/21/13 indicates the injured worker undergoing a right sided selective nerve root block at L5-S1. The MRI of the lumbar spine dated 01/20/14 revealed a posterior disc osteophyte complex measuring 4mm at L5-S1. Moderate narrowing was identified on the right and mild narrowing on the left neuroforamen.

IMR ISSUES, DECISIONS AND RATIONALES

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

1.DISCECTOMY AND TOTAL DISC ARTHROPLASTY L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306.

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, Disc prosthesis.

Decision rationale: The documentation indicates the injured worker complaining of low back pain. Currently, no high quality studies have been published in peer reviewed literature supporting the safety and efficacy of the use of artificial disc replacements in the lumbar region. Without accepted high quality studies supporting the artificial disc replacement in the lumbar region, the requested treatment has not met with positive conclusions regarding the effect of improving the injured worker's outcome. Therefore, this request is not indicated as medically necessary.

2. ASSISTANT PA-C: 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 Other Medical Treatment Guideline or Medical Evidence: Physicians as Assistants at Surgery, 2011 report.

Decision rationale: Given the non medically necessary rationale for the requested surgery, this request is rendered not medically necessary.

3.CO-VASCULAR SURGEON: 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 Other Medical Treatment Guideline or Medical Evidence:Physicians as Assistants at Surgery, 2011 report.

Decision rationale: Given the not medically necessary rationale for the requested surgery, this request is rendered not medically necessary

4. 3 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Hospital Length of Stay.

Decision rationale: Given the not medically necessary rationale for the surgery, the additional request for an inpatient stay is rendered not medically necessary.

5. 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Walking Aids.

Decision rationale: Given the not medically necessary rationale for the surgery, the additional request for postoperative care is rendered not medically certified.

6. 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 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 not medically necessary rationale for the surgery, the additional request for postoperative care is rendered not medically certified

7. 30 DAY COLD THERAPY RENTAL: 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 Official Disability Guidelines (ODG) Low Back Chapter, Heat/Cold.

Decision rationale: Given the not medically certified rationale for the surgery, the additional request for postoperative care is rendered not medically certified.

8. 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 Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports.

Decision rationale: Given the not medically necessary rationale for the surgery, the additional request for postoperative care is rendered not medically necessary.

9. PNEUMATIC INTERMITTENT COMPRESSION DEVICE RENTAL: 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 Official Disability Guidelines (ODG) Knee and Leg Chapter, Venous thrombosis.

Decision rationale: Given the not medically necessary rationale for the surgery, the additional request for postoperative care is rendered not medically necessary.

10. PRE-OP CLEARANCE WITH CXR: 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 Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative testing (general).

Decision rationale: Given the not medically certified rationale for the surgery, the additional request for preoperative testing is rendered not medically necessary.

11. POST-OP PHYSICAL THERAPY X 18: 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 Page(s): 20..

Decision rationale: Given the not medically necessary rationale for the surgery, the additional request for postoperative care is rendered not medically necessary.