

Case Number:	CM14-0031508		
Date Assigned:	07/21/2014	Date of Injury:	08/11/2002
Decision Date:	12/30/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/12/2014

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 and Rehabilitation 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 63-year-old male who reported an injury on 08/11/2002. The mechanism of injury involved a fall. The latest physician progress report submitted for this review is documented on 01/14/2014. The injured worker maintains diagnoses of status post decompression at L3-S1 with posterior spinal fusion at L4-S1, status post removal of hardware, status post revision decompression and discectomy at L3-4, significant disc collapse at L1-2 and L2-3, full thickness right supraspinatus tendon tear, significant foraminal stenosis at C3-5, disc bulges and arthritic changes in multiple levels of the upper thoracic spine, and severe osteoarthritis of the right hip. The injured worker presented with complaints of persistent lower back pain. Previous conservative treatment is noted to include epidural steroid injection, medication management, trigger point injections, and physical therapy. The current medication regimen includes Amitriptyline, Cymbalta, Valium, Norco, Tramadol HCL, Ambien, Gabapentin, Ibuprofen, and Effexor HCL ER. X-rays of the lumbar spine with flexion/extension views were obtained and reportedly revealed severe disc collapse at L2-3 and L1-2 with a slight asymmetric disc collapse and left lateral listhesis of L2 on L3. The physical examination revealed weakness in the bilateral lower extremities, significant atrophy consistent with lumbar radiculopathy on the right, a positive straight leg raise bilaterally, and exquisite tenderness over the SI joints with a positive Fortin's test. The injured worker was given trigger point injections. Treatment recommendations at that time included continuation of the current medication regimen. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hardware L3-L4, L2 Laminectomy and Bilateral L1 and L3 Laminotomies: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter

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, Discectomy/Laminectomy

Decision rationale: 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 electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state prior to a discectomy/laminectomy, there should be documentation of radiculopathy upon physical examination. Imaging studies should reveal nerve root compression, lateral disc rupture, or lateral recess stenosis. As per the documentation submitted, there is no mention of a recent attempt at conservative treatment. There were also no imaging studies provided for review. The medical necessity for the requested procedure has not been established. As such, the request is not medically necessary.

23 Hour Hold: 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-Operative 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.

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.

Cold Therapy Unit: 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 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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.

Post-Operative Physical Therapy 2 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.