

Case Number:	CM14-0061925		
Date Assigned:	08/08/2014	Date of Injury:	05/12/2003
Decision Date:	10/21/2014	UR Denial Date:	04/05/2014
Priority:	Standard	Application Received:	05/03/2014

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 Neurological 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 records presented for review indicate that this 50 year old male was reportedly injured on 05/12/2003. The most recent progress note, dated 06/19/2014, indicates that there were ongoing complaints of chronic low back pain. The physical examination demonstrated lumbar spine palpable paravertebral musculature tenderness with spasm, seated nerve root test is positive, range of motion is guarded and restricted, no evidence of stability on exam, sensation and strength were normal. No recent diagnostic studies were available for review. Previous treatment includes medication, physical therapy, chiropractic care, acupuncture, trigger point injections, and epidural steroid injections. A request was made for L4 to S1 posterior lumbar interbody fusion with instrumentation, neural decompression, and Iliac crest marrow/aspiration/harvesting possible junctional levels, an inpatient hospital stay of two to three days, an assistant surgeon, a front wheel walker, an ice unit, a bone stimulator, a thoracolumbosacral orthosis brace (TLSO), a 3:1 commode, and a medical clearance, all between 3/31/2014 and 7/2/2014. The requests were not certified in the preauthorization process on 04/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 Posterior lumbar interbody fusion with instrumentation, neural decompression, and iliac crest marrow/aspiration/harvesting possible junctional levels: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306, 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Surgery - Discectomy

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) ACOEM - California Guidelines; Low Back Disorders: Clinical Measures; Surgical Considerations - Spinal Fusion (Electronically Cited).

Decision rationale: American College of Occupational and Environmental Medicine (ACOEM) practice guidelines do not support a spinal fusion in the absence of fracture, dislocation, spondylolisthesis, instability, or evidence of tumor/infection. Review of the available medical records document a diagnosis of lumbar radiculopathy, but fail to demonstrate any of the criteria for a lumbar fusion. Furthermore, there are no flexion/extension plain radiographs of the lumbar spine demonstrating instability. Given the lack of documentation, this request is not considered medically necessary.

Inpatient hospital stay of 2-3 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic) (BlueCross BlueShield, 2002) For average hospital LOS after criteria are met, see Hospital length of stay (LOS)

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-Lumbar and Thoracic. Acute and Chronic. Hospital Length of Stay. 8/22/2014.

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare & Medicaid Services (CMS) regarding assistant surgeons (<http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>)

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-Lumbar and Thoracic. Acute and Chronic. Assistant Surgeon. 8/22/2014.

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic) Regarding walking aids (canes, crutches, braces, orthoses, & walkers):

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. Acute and Chronic. Walking Aids. 10/7/2014.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Ice unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic) Regarding continuous-flow cryotherapy:

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC/ODG Integrated Treatment/Disability Duration Guidelines; Shoulder (Acute & Chronic) - Continuous Flow Cryotherapy - (Updated 7/29/14).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Bone stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back - Lumbar & Thoracic (Acute & Chronic) Regarding bone growth stimulators (BGS): and Criteria for use for invasive or non-invasive electrical bone growth stimulators:

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Low Back - Lumbar & Thoracic (Acute & Chronic) (Updated 03/31/14)

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Thoracolumbosacral orthosis (TLSO): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic) Regarding back brace, post operative (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) - Low Back Disorders - Clinical Measures; Devices (Electronically Cited).

Decision rationale: MTUS/ACOEM practice guidelines do not support the use of a lumbar sacral orthosis (LSO) or other lumbar support devices for the treatment or prevention of low back pain except in cases of specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The claimant is currently not in an acute postoperative setting and there is no documentation of instability or spondylolisthesis with flexion or extension plain radiographs of the lumbar spine. As such, this request is not considered medically necessary.

3:1 Commode: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic) Regarding durable medical equipment (DME):

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: The Official US Government Cipher Medicare. Medicare.gov. Durable Medical Equipment. Commode Chairs. (Electronically Cited).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Medical clearance with Internist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 Edition, pages 92-93. Regarding medical clearances: 5. Immediate preoperative visits and other services by Physician.

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: The Merck Manual. Introduction to Care of the Surgical Patient: Care of the Surgical Patient.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.