

Case Number:	CM14-0073368		
Date Assigned:	08/08/2014	Date of Injury:	06/02/2011
Decision Date:	09/12/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	05/20/2014

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 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 61-year-old male who reported an injury on 06/02/2011 after a fall off of a pallet. The injured worker reportedly sustained an injury to his low back and left knee. The injured worker's treatment history included physical therapy, medications, and epidural steroid injections. The injured worker failed to respond to conservative treatment and surgical intervention was requested. The injured worker was evaluated on 02/03/2014. It was noted that the injured worker had progressive pain complaints of the lumbar spine. Physical findings included restricted range of motion secondary to pain with decreased sensation to light touch in the left lateral thigh and calf. The injured worker's diagnoses included advanced degenerative disc disease at the L5-S1, facet and ligament flavum hypertrophy at the L4-5 and L5-S1, and a grade I spondylolisthesis at the L4-5. A request was made for surgical intervention to include laminectomy and lumbar interbody fusion at the L4-5 and L5-S1. There was no request for authorization submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Preoperative 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 Official Disability Guidelines (ODG) Low Back Chapter, Pre-Operative Testing (general).

Decision rationale: The requested preoperative clearance is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address preoperative medical clearance. The Official Disability Guidelines recommend preoperative clearance for injured workers who have comorbidities that can contribute to intraoperative or postoperative complications. The clinical documentation does not provide any evidence that the injured worker has any significant comorbidities that could cause intraoperative or postoperative complications. Furthermore, the clinical documentation does not indicate whether surgical intervention has been authorized or is scheduled. Therefore, the need for preoperative clearance is not medically necessary or appropriate.

Lumbar post-op days 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: The requested lumbar postoperative days inpatient stay is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this type of request. The Official Disability Guidelines recommend a 3 day inpatient stay for a lumbar fusion. The request as it is submitted does not clearly identify the number of days being requested. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested lumbar postoperative days inpatient stay is not medically necessary or appropriate.

Lumbar post-op cold compression unit (rental or purchase unspecified): 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) Shoulder Chapter, Continuous Flow Cryotherapy.

Decision rationale: The requested lumbar postoperative cold compression unit for rental or purchase unspecified is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address this request. The Official Disability Guidelines recommend a 7 day rental of a continuous flow cryotherapy unit following surgical intervention to assist with pain management. The request as it is submitted does not specifically identify a duration of treatment. Furthermore, the clinical documentation does not clearly

address whether surgical intervention has been authorized or is scheduled. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested lumbar postoperative cold compression unit for rental or purchase unspecified is not medically necessary or appropriate.