

Case Number:	CM14-0093866		
Date Assigned:	08/08/2014	Date of Injury:	02/15/2011
Decision Date:	09/29/2014	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	06/20/2014

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 Occupational Medicine 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:

Patient is a 40-year-old male who has submitted a claim for lumbar spine sprain/strain, MRI finding of annular tear and disc bulge, left ankle and foot strain with tendinitis, major depressive disorder, and pain disorder associated with an industrial injury date of 2/15/2011. Medical records from 2013 to 2014 were reviewed. Patient complained of unrelenting low back pain radiating to bilateral lower extremities, associated with numbness and tingling sensation. Physical examination of the lumbar spine showed restricted range of motion, muscle spasm, and tenderness. Straight leg raise test was positive on the left. Sensation was diminished over the L5 and S1 dermatomes, left. Reflexes were intact. Motor strength was graded 5/5. Patient was given psychological clearance to undergo surgery on 2/7/2014. MRI of the lumbar spine, dated 10/27/2013, demonstrated annular degeneration and fissuring with a 0.4 cm subligamentous broad-based protrusion contributing to mild central canal and lateral recess stenosis impinging upon the transversing L5 nerve rootlets at L4-L5 level. There was moderate facet arthropathy that contributes to facet syndrome. At L5-S1 level, there was mild right lateral recess stenosis associated with eccentric disc bulging contacting but not compressing the traversing right S1 nerve rootlet. Treatment to date has included physical therapy, epidural steroid injection, chiropractic care, psychotherapy, and medications. Utilization review from 6/10/2014 denied the request for posterior spinal decompression, and fusion, L4-S1 because there was no documented spinal instability. Hence, all of the associated requests, i.e., chest x-ray, home health care, pre-operative clearance, lab work, chest x-ray, Electrocardiogram (ECG), hospital stay, bone stimulator, lumbar support, and postoperative physical therapy were likewise not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior spinal decompression, and fusion, L4-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Page 127 Official Disability Guidelines (ODG) Low Back Section, Fusion (spinal); Hospital Length of Stay (LOS).

Decision rationale: Regarding lumbar surgery, pages 305 - 307 of CA MTUS ACOEM Guidelines state that lumbar surgical intervention is recommended for patients who have: severe lower leg symptoms in the distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise; activity limitations for more than one month; clear imaging of a lesion; and failure of conservative treatment to resolve disabling radicular symptoms. In ODG, criteria for lumbar fusion should include objectively documented segmental instability and patient should refrain from smoking for at least 6 weeks prior to surgery. In this case, patient complained of unrelenting low back pain radiating to bilateral lower extremities, associated with numbness and tingling sensation. Physical examination of the lumbar spine showed restricted range of motion, muscle spasm, and tenderness. Straight leg raise test was positive on the left. Sensation was diminished over the L5 and S1 dermatomes, left. Reflexes and motor strength were intact. Patient was given psychological clearance to undergo surgery on 2/7/2014. MRI of the lumbar spine, dated 10/27/2013, demonstrated annular degeneration and fissuring with a 0.4 cm subligamentous broad-based protrusion contributing to mild central canal and lateral recess stenosis impinging upon the transversing L5 nerve rootlets at L4-L5 level. There was moderate facet arthropathy that contributes to facet syndrome. At L5-S1 level, there was mild right lateral recess stenosis associated with eccentric disc bulging contacting but not compressing the traversing right S1 nerve rootlet. However, there was no documented instability based on the records submitted. Moreover, there was no evidence of failure of conservative management due to insufficient documentation. Smoking status was likewise not disclosed. Guideline criteria were not met. Furthermore, progress report from 5/23/2014 stated that an updated MRI of the lumbar spine should be accomplished prior to surgery to assess current pathology. However, the MRI result was not made available for review. Given the aforementioned reasons, therefore, the request for posterior spinal decompression, and fusion, L4-S1 is not medically necessary.

Chest x-ray: 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 PROCEDURES.

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.

Home health care times 2 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines HOME HEALTH.

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, 18-24 visits, lumbar spine, to begin 6 weeks post-surgery: 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.

Internal medicine specialist for pre op clearance: 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 PROCEDURES.

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 clearance lab work: 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 PROCEDURES.

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.

Electrocardiography (EKG): 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 PROCEDURES.

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.

Bone stimulator: 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.

Lumbar support: 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.