MAXIMUS Federal Services

Case Number:	CM14-0097577		
Date Assigned:	07/25/2014	Date of Injury:	07/22/2012
Decision Date:	08/28/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/19/2014

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 & Rehabilitation 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 46-year-old female who reported an injury on 07/22/2012. The mechanism of injury was not stated. Current diagnoses include lumbar disc herniation with foraminal stenosis and advanced discogenic changes at the L5-S1 level. The injured worker was evaluated on 04/29/2014 with complaints of constant, severe mechanical axial low back pain with radiation into the bilateral lower extremities. Physical examination was not provided on that date. Previous conservative treatment includes physical therapy, acupuncture, medication management, chiropractic manipulation, behavioral modification, home exercise, and injection therapy. Treatment recommendations included an L5-S1 posterior spinal fusion and decompression with bilateral laminoforaminotomy and microdiscectomy at L3-4 and L4-5. It is noted that the injured worker underwent an MRI of the lumbar spine on 04/08/2014, which indicated minimal lateral disc protrusion on the right at L4-5 and degenerative changes with an annular fissure or tear at L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5 - S1 Posterior Spinal Fusion and Bilateral Laminar Foraminotomies and Microdiscectomies at L3 - 4 and L4 - 5 Levels: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Chapter, http://www.odg-twc.com/odgtwc - Knee & Leg 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, Fusion (spinal).

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is 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 failure of conservative treatment. Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include identification and treatment of all pain generators, completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology limited to 2 levels, and a psychosocial screening. As per the documentation submitted, the injured worker has exhausted conservative treatment. However, there was no physical examination provided on the requesting date. There was no documentation of spinal instability upon flexion and extension view radiographs. There is also no evidence of the completion of a psychosocial screening prior to the request for a lumbar fusion. Based on the clinical information received and the above mentioned guidelines, the request is not medically necessary.

Lumbar Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

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.

Cooling Unit - Rental: 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), Continuous-Flow Cryotherapy.

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.

Spinal Bone Growth 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), Bone-Growth Stimulators (BGS).

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.

Inpatient Stay - 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), Length of Stay (LOS) Guidelines.

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.