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| Case Number: | CM14-0183311 | | |
| Date Assigned: | 12/17/2014 | Date of Injury: | 11/07/2013 |
| Decision Date: | 01/15/2015 | UR Denial Date: | 09/29/2014 |
| Priority: | Standard | Application Received: | 11/04/2014 |

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 Surgery 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 53-year-old male who reported an injury on 11/07/2013. The mechanism of injury involved a fall. The current diagnoses include C5-6 disc degeneration, bilateral cervical radiculopathy, right shoulder impingement with AC joint arthritis, left elbow contusion with mild bursitis, grade 1 spondylolisthesis at L4-5, right leg radiculopathy, L4-5 foraminal stenosis, closed head injury, post traumatic headaches, constipation secondary to narcotics, and post traumatic seizure disorder. The injured worker presented on 09/15/2014 with complaints of persistent neck pain radiating into the shoulder blades, numbness in the bilateral hands, post traumatic headaches, and low back pain radiating into the bilateral lower extremities. The current medication regimen includes Anaprox DS, Norco, Imitrex, Protonix, and Zofran. The physical examination of the lumbar spine revealed an antalgic gait, tenderness to palpation over the lower lumbar spine, right greater than left sacroiliac joint and sciatic notch tenderness, decreased sensation over the right L3 through L5 dermatomes, decreased sensation in the left S1 dermatome, 16 degree flexion, 12 degree extension, 14 degree left lateral bending, 8 degree right lateral bending, 2+ deep tendon reflexes, diminished motor strength in the bilateral lower extremities, positive straight leg raise on the right at 80 degrees, and equal circumferential measurements. Treatment recommendations at that time included an L4-5 AP fusion with cage and instrumentation with bilateral L4-5 laminotomy and foraminotomy. A Request for Authorization was then submitted on 09/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 AP fusion with cage and instrumentation, bilateral L4-5 laminotomies and foraminotomies: 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 - Indications for Surgery--Discectomy/laminectomy

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: The 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 a failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. As per the documentation submitted, there were no imaging studies provided for this review. There was no documentation of spinal instability upon flexion and extension view radiographs. Previous conservative treatment was not mentioned. There was also no documentation of a psychosocial assessment 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.

Physical therapy 3 times a week for 6 weeks for a total of 18 visits: 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.

Preoperative medical clearance with chest x-ray: 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 back 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.

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 wheel 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.

3-in-1 commode: 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.