

Case Number:	CM14-0193116		
Date Assigned:	12/01/2014	Date of Injury:	07/29/1997
Decision Date:	01/21/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/18/2014

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 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 57-year-old male who reported an injury on 07/29/1997. The mechanism of injury was not provided within the submitted medical records. The injured worker's diagnoses included degeneration of the lumbar spine, and facet arthropathy. Current medications and surgical history were not provided within the submitted medical records. Diagnostic studies include an MRI of the lumbar spine completed on 07/28/2014 that documented at L5-S1. There was documented loss of disc height and bilateral facet hypertrophy and minimal bilateral facet joint effusions with mild dural compression contacting the exiting left L5 nerve. Other therapies at the L5-S1 level were not provided within the submitted medical records. There was however, documentation of epidural steroid injections at the L4-5 level with recommended physical therapy with no documentation that physical therapy had been completed recently. The clinical report on 11/13/2014 documented the injured worker was complaining of low back pain with associated radicular symptoms in the bilateral lower extremities. The physical exam noted that the injured worker had pain with extension and rotation along with paraspinal spasms. There was decreased sensation in the L5 nerve root distribution with associated weakness. The injured worker was also documented as having walked with an antalgic gait with neurogenic claudication symptomatology. It was documented that the provider stated the injured worker had instability that was evident through diagnostic imaging, but there was no provided diagnostic imaging within the submitted medical records to establish instability in the lumbar spine at the requested level for surgery. The rationale for the request at this time is to help address radicular symptoms from the requested level for surgical intervention. A Request for Authorization was provided within the submitted medical records for the requested procedure dated 10/20/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 Posterior Lumbar Interbody Fusion at Hospital: Upheld

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

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

Decision rationale: The request for an L5-S1 posterior lumbar interbody fusion is not medically necessary. The California MTUS/ACOEM Guidelines state that except for cases of trauma related spinal fracture or dislocation, fusion of the spine is not usually considered during the first 3 months of symptoms. Injured worker's with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatments. There is no good evidence from controlled trials that spinal fusion alone is effective in treating any type of acute low back problems, in the absence of spinal fracture, dislocation, or spondylolisthesis if there any instability and motion in the segment operated on. Within the submitted medical records, it was opined by the provider that the injured worker had spondylolisthesis, but lacked corroborating diagnostic imaging for the declaratory statement. Moreover, the injured worker did not present with significant conservative therapies as the injured worker was recommended for an L4-5 epidural steroid injection, but not at the level being requested for the fusion. There was no documentation that the injured worker had undergone recent physical therapy prior to the request. Lastly, there was lack of documentation to show the patient had psychological clearance prior to the request. Without further documentation to address the aforementioned deficiencies outlined in the review, the request is not supported by the guidelines. As such, the request is not 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)

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 hospital stay, 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)

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 medical clearance with an internal medicine specialist to include: labs (CMP, PT, PTT, CBC, UA), EKG, and chest x-ray and post-operative hospital visits with internal medicine specialist: 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 and Official Disability Guidelines (ODG)

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 brace: 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)

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.

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)

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.

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)

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.

DVT machine with cuffs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Neuroscience Nurses (AANN) page 41

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 sessions of in-home physical therapy x 8: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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 sessions of physical therapy x 8: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 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.

RN evaluation for wound check with possible home health aide 2-3 hours/day, 2-3 times/week for 4 weeks: 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)

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.