

Case Number:	CM14-0207806		
Date Assigned:	12/19/2014	Date of Injury:	04/30/2002
Decision Date:	02/28/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	12/11/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas

Certification(s)/Specialty: Orthopedic Surgery

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 50-year-old male who reported an injury on 04/30/2002. The mechanism of injury was not provided. The diagnoses included reflex sympathetic dystrophy of the upper limb, cervical spondylosis with myelopathy, cervical intervertebral disc degeneration, cervical postlaminectomy syndrome, lumbago, and thoracic/lumbosacral neuritis/radiculitis. The documentation of 10/31/2014 indicated the injured worker reported persistent low back pain. The physical examination revealed severely limited range of motion in flexion and extension. The injured worker had some tenderness to palpation in the sciatic notches bilaterally. The motor examination in the lower extremities was grossly intact at 5/5, including iliopsoas, quadriceps, hamstrings, gastrocnemius, anterior tibialis, foot inversion and eversion, and EHL. Sensation was decreased in the S1 distribution bilaterally. The injured worker had absent ankle reflexes in the lower extremities bilaterally. The treatment plan included an anterior lumbar interbody fusion at L5-S1, a repeat MRI, a preoperative evaluation and clearance for surgery, a lumbar LSO, postoperative x-rays to be obtained 6 weeks postoperatively, and a bone fusion stimulator due to the patient's smoking. There was a Request for Authorization submitted on 10/31/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Low Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Magnetic Resonance Imaging (MRI).

Decision rationale: The California MTUS/ACOEM Practice Guidelines state, if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. The Official Disability Guidelines recommend repeat studies are recommended for patients who have a significant change in objective or subjective findings. The clinical documentation submitted for review indicated the injured worker had a prior MRI. There was a lack of documentation indicating the injured worker had a significant change in symptoms or objective findings to support the necessity for a repeat study. Given the above, the request for an MRI of the lumbar spine is not medically necessary.

L5-S1 Decompression and Fusion with Instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation ODG Fusion (spinal)

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 limitations 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. There was documentation of an exhaustion of conservative care. However, as there was a lack of documentation of official imaging and electrophysiologic evidence, this request would not be supported. There is no evidence of instability upon flexion/extension view radiographs. There is also no mention of a psychosocial screening. Given the above, the request for and L5-S1 decompression and fusion with instrumentation is not medically necessary.

Post-op X-rays Lumbar Spine 4 views: 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.

Post Op Physical Therapy 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.

Lumbar LSO: 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.

Bone Fusion 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.

Pre-operative Clearance: 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.