

Case Number:	CM14-0093169		
Date Assigned:	08/11/2014	Date of Injury:	10/28/2009
Decision Date:	01/05/2015	UR Denial Date:	06/13/2014
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 Orthopedic Spine Surgeon 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 female who reported an injury on 10/28/2009. The mechanism of injury was not specifically stated. The current diagnoses include status post C4-6 anterior cervical discectomy and fusion, thoracic spine strain, right knee pain, status post left knee arthroscopic surgery with degenerative joint disease, status post left carpal tunnel release on 03/18/2011, status post right carpal tunnel release on 07/01/2011, status post left cubital tunnel release and status post right cubital tunnel release with medial epicondylectomy. The injured worker presented on 05/20/2014 with complaints of ongoing symptomology in the lumbar spine with extension into the lower extremities. Previous conservative treatment is noted to include activity modification, physical therapy, medication management, and lumbar epidural steroid injections. Physical examination of the lumbar spine revealed tenderness from the mid to distal lumbar segments, pain with terminal motion, positive seated nerve root test, and dysesthesia at the L5 and S1 dermatomes. Treatment recommendations at that time included a posterior lumbar interbody fusion at L5-S1. There was no Request for Authorization form submitted for this review.

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 with possible reduction of listhesis: 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-

Treatment in Worker's Compensation, Low Back Procedure Summary(last updated 05/12/2014) ,
Criteria for lumbar spinal fusion and Indications for Surgery- Discectomy

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 may be indicated for patients who have severe and disabling lower extremity symptoms; activity limitation for more than 1 month; clear clinical, imaging, and electrophysiological evidence of a lesion; and 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 myelopathy, spine pathology that is limited to 2 levels, and a psychosocial screening. As per the documentation submitted, there was no evidence of spinal instability upon flexion and extension view radiographs. There was no documentation of a psychosocial screening prior to the request for a lumbar fusion. Based on the clinical information received, the injured worker does not currently meet criteria for the requested procedure. As such, the request is not medically necessary.

Associated surgical service: Inpatient hospital stay for 2-3 days: 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.

Associated surgical service: Assistant surgeon: 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.

Associated surgical service: Front wheel walker (for purchase): 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.

Associated surgical service: Ice unit (for purchase): 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.

Associated surgical service: 3 in 1 commode (for purchase): 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.

Associated surgical service: TLSO brace(Thoracolumbosacral Orthosis) for purchase: 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.

Associated surgical service: Bone stimulator(for purchase): 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.

Associated surgical service: Medical clearance with internist (unspecified): 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.