

Case Number:	CM15-0016488		
Date Assigned:	02/04/2015	Date of Injury:	01/03/2000
Decision Date:	05/01/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	01/28/2015

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: California

Certification(s)/Specialty: Pediatrics, Neurological 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 49 year old male who sustained a work related injury January 3, 2000. Past history included s/p lumbar laminectomy and discectomy L5-S1, diabetes and hypertension. According to a neurological consultation dated December 9, 2014, the injured worker presented with complaints of constant severe sharp mechanical axial back pain, which is always present and affects functionality and lifestyle. There is sever leg radiculopathies, left greater than right, including pain numbness and weakness, more down the posterior portion of his leg to the bottom of his foot. Diagnoses included recurrent disc herniation's L4-S1 with high grade foraminal stenosis towards the right and critical foraminal stenosis towards the left; significant disc herniation at L3-4 level and bilateral foraminal stenosis; marked disc deterioration, Modic changes, endplate deterioration and facet arthropathy L4-S1. Treatment plan included request for authorization for surgery and post-operative treatment and equipment. According to utilization review dated January 22, 2015, the request for L4-S1 posterior spinal fusion with L3-4 bilateral laminar foraminotomy and microdiscectomy is non-certified, citing MTUS ACOEM Guidelines, Low Back Complaints and ODG Indications for Surgery-Discectomy. The request for a (3) Day In-Patient stay is non-certified, citing ODG Low Back- Lumbar &Thoracic (Acute & Chronic). The request for (1) LSO Lumbar Brace is non-certified, citing ODG Low Back- Lumbar& Thoracic (Acute & Chronic). The request for (1) Walker is non-certified, citing ODG, Hip & Pelvis (Acute & Chronic). The request for (1) Bone Stimulator is non-certified, citing ODG Low Back (Acute & Chronic). The request for (1) Cooling Unit with Pads is non-certified, citing

MTUS ACOEM Guidelines-Low Back Complaints and ODG, Low Back- Lumbar & Thoracic (Acute & Chronic).

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 posterior spinal fusion with L3-L4 bilateral laminar foraminotomy and microdiscectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion(Spinal), Foraminotomy.

Decision rationale: The request is not supported. The patient does have decreased range of motion with diminished sensation and reflexes. There is a 4/5 strength on his left iliopsoas, quadriceps and hamstrings. His anterior tibialis and extensor hallucis longus muscles are -5/5 on the right and 4+/5 on the left. His gastrocnemius muscles are a -4/5 on the right and 4+/5 on the left. The MRI shows significant disc herniations bilaterally at the L3-S1 levels with 75% foraminal stenosis at the L3-4 level and almost complete foraminal stenosis at the L4-5 level. The Official Disability Guidelines indicate that preoperative clinical surgical indications include all pain generators being identified and treated. There needs to be a psychosocial screen with confounding issues addressed. There is no documentation of the patient having a psychosocial screen completed. Therefore, the request for L4-S1 posterior spinal fusion with L3-4 bilateral laminar foraminotomy and microdiscectomy is not medically necessary.

Associated surgical service: 3-day inpatient stay: 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.

Associated surgical service: 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), 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.

Associated surgical service: 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.

Associated surgical service: bone 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).

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: cooling unit with pads: 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.