

Case Number:	CM15-0138938		
Date Assigned:	08/03/2015	Date of Injury:	03/10/2013
Decision Date:	09/28/2015	UR Denial Date:	07/10/2015
Priority:	Standard	Application Received:	07/20/2015

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: 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 sustained an industrial injury on 3-10-13. The mechanism of injury was unclear. He currently complains of persistent neck and low back pain with numbness and tingling in the lower extremities. His pain is constant and wakes him up at night. On physical exam of the lumbar spine there was decreased range of motion with positive straight leg raise, tenderness to palpation and muscle guarding in the paraspinal musculature; the cervical spine revealed tenderness to palpation in the cervical spine musculature. Medications were Norco, Anaprox, Prilosec, Neurontin, medical marijuana. Diagnoses include lumbar sprain, strain with left radiculopathy; lumbar sprain, strain with right sided radiculopathy; cervicocranial syndrome; cervical sprain, strain; bilateral carpal tunnel syndrome; medication induced gastritis. Treatments to date include medications; lumbar epidural steroid injection with 50% benefit. Diagnostics include MRI of the lumbar spine (6.17.14) showing disc protrusion, facet hypertrophy, impingement, posterior annular tear, and fissure; electromyography, nerve conduction of bilateral lower extremities (11.25.14) revealed acute L5 radiculopathy on the left; electromyography, nerve conduction of bilateral upper extremities (11.25.14) revealing bilateral carpal tunnel syndrome and bilateral moderate to severe cubital tunnel syndrome. In the progress note dated 6.9.15 the treating provider's plan of care included request for lumbar spine decompression surgery, specifically L4-5 and L5-S1 decompression, foraminotomies and partial facetectomies and transforaminal lumbar interbody fusion; pre-operative medical clearance including complete blood count, chest x-rays, electrocardiogram, basic metabolic panel, urinalysis; inpatient physical therapy x 7 visits; outpatient physical therapy x 24 days; cold

therapy unit for 14 days; elevated toilet seat; front wheel walker; a grabber, LSO brace; interferential, transcutaneous electrical nerve stimulator unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 and L5-S1 decompression, foraminotomies and partial facetectomies and TLIF interbody fusion with cages and bone graft: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306, 310. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar and Thoracic Chapter (online version) Fusion (spinal), Discectomy.

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 Chapter, Spinal fusion.

Decision rationale: The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 states that lumbar fusion, except for cases of trauma-related spinal fracture or dislocation, is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient, there is lack of medical necessity for lumbar fusion, as there is no evidence of segmental instability greater than 4.5 mm, severe stenosis or psychiatric clearance from the exam note of 6/9/15 to warrant fusion. Therefore, the request is not medically necessary.

Pre-operative medical 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.

Associated surgical service: CBC: 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: Chest x-rays: 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: EKG: 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: BMP: 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: U/A: 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: Inpatient physical therapy (7-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.

Associated surgical service: Outpatient physical therapy (24-sessions): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision. Char Format.

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: Cold therapy unit (14-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: Elevated toilet seat: 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-wheeled 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.

Associated surgical services: Grabber: 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.