

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0232647 | | |
| Date Assigned: | 12/08/2015 | Date of Injury: | 09/10/2014 |
| Decision Date: | 01/29/2016 | UR Denial Date: | 11/16/2015 |
| Priority: | Standard | Application Received: | 11/27/2015 |

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, Indiana, Oregon
 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-work injury on 9-10-14. The injured worker was diagnosed as having strain of muscle fascia and tendon of the lower back; thoracic, lumbosacral disc disorder, and sprain-strain of back. Treatment to date has included medication and diagnostics. CT scan reports were reported on 9-21-15 of the lumbar spine that noted diffuse disc bulging right sided protrusion, prominent osteophyte formation and bilateral facet arthropathy at L5-S1 producing foraminal stenosis and impingement left and right L5 nerves and some on the right S1 nerve, posterior disc bulging at L4-5. EMG-NCV (electromyography and nerve conduction velocity test) was reported on 7-24-15 that supported chronic L5 nerve root irritation on the right, deep accessory peroneal nerve on the right, and no evidence of peripheral neuropathy in the lower extremities. Currently, the injured worker complains of pain in the lower back that was dull and sharp and rated 6 out of 10 (not specific with or without medication). Per the primary physician's progress report (PR-2) on 10-13-15, exam noted negative straight leg raise and reduced range of motion to the lumbar region. Current plan of care includes back restrictions and referral to spine specialist and surgery. The Request for Authorization requested service to include L4-L5 ADR, L5-S1 ALIF with/BMP and Allograft, Preoperative Medical Clearance, Bone Stimulator Purchase, Lumbar X-ray Flex/ Ext, Postoperative physical Therapy 3x a week for 4 weeks, Cold Therapy unit Rental, and Lumbar Brace. The Utilization Review on 11-16-15 denied the request for L4-L5 ADR, L5-S1 ALIF with/BMP and Allograft, Preoperative Medical Clearance, Bone Stimulator Purchase, Lumbar

X-ray Flex/ Ext, Postoperative physical Therapy 3x a week for 4 weeks, Cold Therapy unit Rental, and Lumbar Brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 ADR, L5-S1 ALIF with/BMP and Allograft: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back.

Decision rationale: Fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine 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 symptoms. 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 notes to warrant fusion. Therefore the request is not medically necessary.

Preoperative 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Bone Stimulator 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Lumbar X-ray Flex/ Ext: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Postoperative physical Therapy 3x a week for 4 weeks: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Cold Therapy unit Rental: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Lumbar Brace: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.