

Case Number:	CM14-0210403		
Date Assigned:	12/23/2014	Date of Injury:	06/05/2012
Decision Date:	05/13/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/15/2014

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 35-year-old male who reported an injury on 06/05/2012. The mechanism of injury was reported as, while working on his knees and flexed forward; the injured worker straightened up and felt a sudden pop and pain in his low back and across his left hip area. His diagnosis was noted as lumbar disc displacement, radiculopathy left leg. His past treatments were noted to include surgery, physical therapy, medication, and activity modification. His surgical history was noted to include lumbar fusion performed on 10/09/2012. During the assessment on 04/22/2014, the injured worker complained of low back pain. He rated his pain a 9/10. He also complained of severe pain in the left knee. Physical examination of the lumbar spine revealed unchanged range of motion with flexion to 45 degrees, extension to 30 degrees, and right/left turns each to 45 degrees. There was tenderness at the mid lumbar L3-5 level. His medication was noted to include Ultram 150 mg. The treatment plan was to continue with medication, work modification, and request consultation with provider. The rationale for the request was not provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

L2-L4 remove and explore, TLIF, L2-S1 PSF/PSI-3 day IP stay with Surgical Assistant:
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: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

Decision rationale: The request for L2-L4 remove and explore, TLIF, L2-S1 PSF/PSI-3 day IP stay with Surgical Assistant is not medically necessary. The California MTUS/ACOEM Guidelines state that patients with increased spinal instability (not work related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. The clinical documentation indicates that the injured worker underwent a spinal fusion on 10/09/2012. The most recent clinical documentation provided dated 02/22/2014, provided limited evidence of instability at L2-4. There was limited evidence of symptoms related to the L2-4 hardware. As such, the requested surgery is not supported. In regard to the 3 day inpatient stay with surgical assistant, as the requested surgical intervention was found not medically necessary at this time, the requested 3 day inpatient stay with surgical assistant is also not supported. Given the above, the request is not medically necessary.

DME: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

External Bone Growth 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: As the requested surgical intervention is Since the primary procedure is not medically necessary, none of the associated services are medically necessary. not supported by the documentation, the requested ancillary service is also not supported.

Physical Therapy 3x wk, x6 wks: 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.

1 Box Island Bandage: 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.