

Case Number:	CM15-0124793		
Date Assigned:	07/15/2015	Date of Injury:	10/10/2009
Decision Date:	08/10/2015	UR Denial Date:	02/14/2015
Priority:	Standard	Application Received:	06/29/2015

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: New York

Certification(s)/Specialty: 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 47 year old female, who sustained an industrial injury on 10/10/09. Initial complaints were back pain and broken foot. The injured worker was diagnosed as having; lumbar radiculopathy; right foot fracture/ORIF 10/11/09; right hip tendinitis/bursitis; right lower extremity radiculopathy; right foot strain/sprain-fracture. Treatment to date has included physical therapy; acupuncture; Series of 3 epidural steroid injection lumbar (11/8/12); right ankle injections; shock-wave therapy lumbar spine; psychology evaluation; orthopedic consultations; medications. Diagnostics studies included MRI right foot (2009); EMG/NCV study bilateral lower extremities (3/26/12); MRI lumbar spine (3/26/12; 5/2013). Currently, the PR-2 notes dated 1/8/15 indicated the injured worker complains of back pain and disc herniation in the lumbar spine at L4-L5. She was previously recommended to have a fusion at L4-L5 and L5-S1. She has clear disc space collapse at L4-L5 and L5-S1 and also has Modic changes in the spine in both endplates of L4-L5 and L5-S1, which more than likely has contributed to the injured worker's loss of disc height. She has continued motion with back pain and suffering with pain and discomfort. She has no new motor or sensory deficits, 20 degrees flexion, extension, right/left lateral rotation and bending. The provider notes the range of motion is severely limited and hip examination was negative. The provider is at this time noting a treatment plan to include recommended lumbar decompression and fusion at L4-L5 and L5-S1. He notes a positive physical examination, positive MRI and objective tests, failed non-operative treatment and chronic low back pain which is unrelenting. The provider is requesting authorization of Lumbar Decompression including Laminectomy, Discectomy, Facetectomy, Foraminotomy and Fusion

from L4-S1 with Iliac Crest Bone, Graft and Instruments including Cages and Pedicle Screws; intra-operative monitoring service including SSEP and EMG; cell saver; assistant surgeon; pre-operative medical clearance; pre-operative EKG; pre-operative Labs, pre-operative chest X-ray; pre-operative lumbar spine X-ray;. pre-operative MRI lumbar spine; lumbar back brace; bone stimulator; 3-1 commode shower chair; Cold therapy rental 7 days; post-operative physical therapy 8 visits; post-operative office visits x6 visits and 2-4 day Inpatient Stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Decompression including Laminectomy, Discectomy, Facetectomy, Foraminotomy and Fusion from L4-S1 with Iliac Crest Bone, Graft and Instruments including Cages and Pedicle Screws: 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, Discectomy/Laminectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-7.

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Lumbar Decompression including Laminectomy, Discectomy, Facetectomy, Foraminotomy and Fusion from L4-S1 with Iliac Crest Bone, Graft and Instruments including Cages and Pedicle Screws is not medically necessary and appropriate.

Associated Surgical Service: Intra-operative Monitoring Service including SSEP and EMG: 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.

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.

Pre-Operative 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.

Pre-Operative Labs: 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.

Pre-Operative Chest X-Ray: 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.

Pre-Operative Lumbar Spine X-Ray: 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.

Pre-Operative MRI Lumbar Spine: 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: Cell Saver: 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: Lumbar Back 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.

Associated Surgical Service: Bone 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Service: 3-1 Commode Shower Chair: 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: Cold Therapy Unit Rental for 7 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.

Post-Operative Physical Therapy 8 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.