

Case Number:	CM15-0126470		
Date Assigned:	07/15/2015	Date of Injury:	10/28/2002
Decision Date:	09/14/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/30/2015

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 62 year old male who sustained an industrial /work injury on 10/28/02. He reported an initial complaint of pain to neck, lower back, and right shoulder. The injured worker was diagnosed as having L5-S1 discogenic back pain with foraminal narrowing and radiculopathy. Treatment to date includes medication, epidural steroid injections, diagnostics, and therapy. MRI lumbar spine from 10/8/14 demonstrates neural foraminal narrowing at the left L4/5 and mild to moderate on the right at L5/S1. EMG/NCV (electromyography and nerve conduction velocity test was done on 5/20/14 and 11/6/14. Per the primary physician's report (PR-2) on 4/27/15, midline and paraspinal tenderness in lumbar spine, decreased range of motion of the lumbar spine, straight leg raise test is positive, and limitations of activities of daily living. The requested treatments include decompression & fusion with instrumentation L5-S1, internal medicine pre-op clearance, RN assessment for post-op wound care & home health aide as needed, DVT Unit (Indefinite use), front wheel walker, 3-in-1 commode, LSO Back Brace, Bone Growth Stimulator, and Motorized Cold Therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decompression & Fusion with instrumentation L5-S1 QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation 2012 on the web (www.odgtreatment.com), Work Loss Data Institute Section: Low Back (updated 1/30/12).

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).

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, 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 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 4/27/15 to warrant fusion. Therefore the determination is not medically necessary for lumbar fusion.

Internal Medicine Pre-op 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.

RN assessment for post-op wound care & home health aid as needed: 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.

DVT Unit (Indefinite use) QTY 1: 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.

Front Wheel Walker QTY 1: 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.

3-in-1 commode QTY 1: 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.

LSO Back Brace QTY 1: 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.

Bone Growth Stimulator QTY 1: 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.

Motorized Cold Therapy QTY 1: 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.