MAXIMUS Federal Services

Case Number:	CM15-0166740		
Date Assigned:	09/11/2015	Date of Injury:	11/07/2008
Decision Date:	11/06/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	08/25/2015

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 55-year-old male who sustained an industrial injury on 11-7-08. Diagnoses are sprain-strain lumbar region, brachial neuritis-radiculitis, tear meniscus or other tear cartilage of knee-current, and sprain-strain cruciate ligament. Previous treatment includes an MRI-lumbosacral spine 7-25-12, x-rays, medications, and a history of lumbar spine surgery in 2008. In a progress report dated 7-10-15, the treating physician notes subjective complaints of lower back pain and that it is causing problems on his knee and the way he walks. Medications are Norco and Naproxen. Lumbar motion is decreased in all directions 10-15 degrees with pain. Tenderness and triggers are present. Sensory is decreased along the right L4-L5 dermatomes. There is motor weakness along the right S1 dermatome. His gait is antalgic and he uses a cane. The plan is an L5-S1 fusion. Work status is noted as permanent restrictions. In an agreed medical examination dated 8-3-15, it is noted that since the last visit on 6-3-14, the injured worker reports his low back discomfort has increased and he experiences radiating discomfort from his low back to his feet with intermittent numbness and tingling. He notes his symptoms are exacerbated with sitting longer than 20 minutes, bending, walking, or standing. An MRI of the lumbar spine is recommended. The requested treatment of L5-S1 posterior interbody decompression-fusion allografting any repairs, pre-operative clearance, assistant surgeon, associated surgical service: inpatient stay of 3-4 days, associated surgical service: walker, associated surgical service: cold therapy unit, Ultracet 37.5-325mg #60, and post-operative physical therapy 3 times a week for 4 weeks was not approved on 8-7-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 posterior interbody decompression/fusion allografting any repairs: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Lumbar fusion.

Decision rationale: According to the ACOEM Guidelines, 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 Official Disability Guidelines, 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 7/10/15 to warrant fusion. Therefore, the request is not medically necessary.

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.

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: Inpatient stay 3-4 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: 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 service: Cold therapy unit: 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.

Ultracet 37.5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification).

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 7/10/15. Therefore, the request is not medically necessary.

Post-op physical therapy, 3 times 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.