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| Case Number: | CM15-0075352 | | |
| Date Assigned: | 05/04/2015 | Date of Injury: | 10/26/2010 |
| Decision Date: | 06/02/2015 | UR Denial Date: | 04/09/2015 |
| Priority: | Standard | Application Received: | 04/20/2015 |

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 42 year old male, who sustained an industrial injury on October 26, 2010. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having bilateral shoulder impingement syndrome, lumbar 5-sacral 1 disc displacement with history of previous industrial injury and lumbar 5-sacral 1 disc degeneration, bilateral shoulder superior labral tear from anterior to posterior tear, impingement, and acromioclavicular joint degenerative joint disease; bilateral knee degenerative joint disease, left knee patellofemoral chondromalacia, cervical strain, left knee internal derangement, and lumbar radiculopathy. Diagnostics to date has included MRI and x-rays. Treatment to date has included trigger point injections and opioid pain medication. On March 30, 2015, the injured worker complains of mid to low back pain radiating into the bilateral buttocks, with tingling down the bilateral posterior thighs through the calves, with numbness into the plantar aspect of the feet. The physical exam revealed a normal gait, no weakness with toe and heel walking, tenderness to palpation lower lumbar at lumbar 5-sacral 1, intact sensation of the bilateral lower extremities, and decreased bilateral ankle reflexes. The motor exam of the bilateral lower extremities was normal, except for trace weakness of the right extensor hallucis longus (EHL). The treatment plan includes changing his pain medication from Norco to Hysingla, lumbar-sacral orthosis (LSO) brace, pneumatic intermittent compression device, postoperative physical therapy, pre-operative medical clearance, and a chest x-ray. The injured worker was temporarily totally disabled. The requested treatments are a psyche consult, lumbar 5-sacral 1 anterior fusion & cage, lumbar-sacral orthosis (LSO) back brace, pneumatic

intermittent compression device, 3 in 1 commode, cold therapy unit, chest x-ray, assistant surgeon, 3 day in hospital stay, and Hysingla ER.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 Anterior & Posterior Fusion with Cage & Instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic (Acute & Chronic), Fusion (spinal); CPT Procedure Index.

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

Decision rationale: 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 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 support this. 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 requested treatment: L5-S1 Anterior & Posterior Fusion with Cage & Instrumentation is NOT Medically necessary and appropriate.

Associated surgical service: LSO 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: 30 days Pneumatic intermittent compression device: 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-in-1 Commode: 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.

Pre-Operative Medical Clearance with 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.

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: 3 Days In-Patient Hospital Stay: 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.

Hysingla ER (Hydrocodone Bitartrate) 30mg: 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: 1 Psych Consultation (only) for surgery 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.