MAXIMUS Federal Services

Case Number:	CM15-0078449		
Date Assigned:	05/05/2015	Date of Injury:	02/25/2002
Decision Date:	06/08/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	04/23/2015

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 2/25/2002. He reported twisting his neck and low back after helping to carry a rebar cage. The injured worker was diagnosed as having status post anterior lumbar fusion, bilateral carpal tunnel syndrome, bilateral upper extremity numbness, cervical disc herniation, and lumbar spine degenerative disc disease. Treatment to date has included medications, physical therapy, magnetic resonance imaging, nerve studies of the arms and legs, carpal tunnel surgery, and previous low back surgery. The request is for: 3-in-1 commode, bone growth stimulator, co-surgeon, consultation for possible anterior approach, Fexmid, front wheeled walker, inpatient stay for 3 days, intraoperative neuromonitoring, LSO brace, Norco, open decompression at L5-S1 and anterior posterior lumbar spinal fusion at L5-S1 with graft and instrumentation, post-operative home health care, post-operative home health evaluation, pre-operative psychiatric clearance, and pre-operative medical clearance. On 4/14/2015, he complained of low back pain with radiation to the lower extremities bilaterally, bilateral leg numbness, and neck pain. He rated his pain from 7- 9/10 without medications and as low as 3/10 with medications. The treatment plan included: lumbar decompression and fusion, Norco, and Fexmid.

IMR ISSUES, DECISIONS AND RATIONALES

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

Open Decompression at L5-S1 and Anterior Posterior Lumbar Spinal Fusion at L5-S1 with Graft and Instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Low Back Chapter, Fusion (Spinal).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-307.

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 provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. Documentation does not provided evidence of a home exercise program. 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: Open Decompression at L5-S1 and Anterior Posterior Lumbar Spinal Fusion at L5-S1 with Graft and Instrumentation is NOT Medically necessary and appropriate.

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.

Associated surgical service: Co-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: Consult for possible anterior approach: 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 Psyche 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.

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.

Post-Operative Home Health Care 4 x 5 x 2: 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 Home Health Evaluation: 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 x 3 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: Front Wheel 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: LSO 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 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Fexmid 7.5mg, One tablet three times per day #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Spasmodics Page(s): 64.

Decision rationale: The California MTUS guidelines only recommend cyclobenzaprine, an anti-spasmodic for short courses. These are defined as 2-3 weeks. The guidelines do not recommend chronic use of the drug. The requested treatment for Fexmid 7.5mg, one tablet three times per day #90: is not medically necessary and appropriate.

Norco 10/325mg, up to six tablets per day for pain #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids for neuropathic pain Page(s): s 81-82.

Decision rationale: The California MTUS guidelines note there is no evidence that opioids provide long term benefit in improvement of function in the treatment of chronic back pain. Documentation does not provide evidence of improvement of function, as the patient is not back to work. The guidelines also note that opioids are not recommended as first line treatment for back pain. The requested treatment Norco 10/325mg, up to six tablets per day for pain #180 is not medically necessary and appropriate.

Associated surgical service: Intraoperative Neuromonitoring: 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.