

Case Number:	CM14-0185661		
Date Assigned:	11/14/2014	Date of Injury:	03/28/2013
Decision Date:	05/11/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/06/2014

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: Texas
 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 32-year-old male who reported an injury on 03/23/2013. The mechanism of injury was a slip and fall. He is diagnosed with lumbago, lumbar sprain, and acquired spondylolisthesis. His treatment has included modified duty, anti-inflammatory medications, use of a back brace, and physical therapy. It was noted that x-rays were obtained following his injury and were noted to reveal no evidence of fractures or dislocations. An MRI of the lumbar spine was noted to reveal mild discogenic disease at L5-S1 associated with grade 1 anterolisthesis and bilateral L5 pars defects, a 3 mm broad based disc protrusion at L5-S1 that does not result in compromise of the central spinal canal or neural foramina, and normal facet joints. However, the official MRI report was not provided to verify these findings. The injured worker's symptoms were noted to include low back pain. His physical examination findings included decreased motor strength to 4/5 in right ankle dorsiflexion, right great toe extension, left ankle dorsiflexion, and left great toe extension. He was also noted to have decreased reflexes at the left knee and positive straight leg raising bilaterally. His sensation was noted to be normal throughout the bilateral lower extremities. A rationale for the requested surgery and associated services was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 Anterior/Posterior decompression fusion with instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-306.

Decision rationale: According to the California MTUS/ACOEM Guidelines, spinal surgery may only be considered when serious spinal pathology and/or nerve root dysfunction has been unresponsive to at least 3 months of conservative therapy and is obviously due to a herniated disc. Documentation should show: severe and disabling radiating symptoms in a distribution consistent with abnormalities on imaging studies, as well as accompanying objective signs of neural compromise; activity limitations due to radiating extremity pain that have been present for more than 1 month, or an extreme progression of radiating symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit from surgical repair; and the failure of at least 3 months of conservative treatment to resolve disabling radicular symptoms. Additionally, the guidelines state that spinal fusion may be considered when there is clear evidence of instability. The documentation failed to indicate whether the injured worker had significant radiating symptoms in an L5-S1 distribution, which resulted in decreased function. The submitted documentation only indicated that he had low back pain without a description of significant neuropathic pain or pain in a specific distribution into either lower extremity. He was noted to have neurological deficits in the bilateral lower extremities consistent with pathology at L5-S1. Further, an MRI was noted to reveal significant pathology at L5-S1 to include a grade 1 anterolisthesis and protrusion. However, it was noted that these findings did not result in compromise of the neural foramina. The official MRI report was not provided to verify findings at this level. Further, there was no evidence or notation to suggest imaging findings to support fusion of the lumbar spine. In the absence of documentation regarding the injured worker's symptoms and official imaging to support the requested decompression and fusion, the request is not supported. As such, the request is not 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.

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.

Physical therapy x 12 for low back: 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.

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.

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.

Hospital stay x 2 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.

Intra Operative monitoring: 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-op 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.