

Case Number:	CM15-0101741		
Date Assigned:	06/03/2015	Date of Injury:	01/08/2007
Decision Date:	07/10/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	05/27/2015

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 59 year old male, who sustained cumulative industrial injuries from 1975 through 2007. He reported low back pain and bilateral knee pain. The injured worker was diagnosed as having lumbar disk disease, lumbar radiculopathy, obesity, synovial cyst at the lumbar facet, status post right knee arthroscopy and bilateral internal derangement of the knees. Treatment to date has included radiographic imaging, diagnostic studies, lumbar epidural steroid injections, conservative therapies, physical therapy, chiropractic care, home exercises, medications and work restrictions. Currently, the injured worker complains of continued low back pain with associated numbness and tingling of the bilateral lower extremities. The injured worker reported cumulative industrial injuries from 1975 through 2007, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. Evaluation on March 4, 2015, revealed continued pain as noted. He reported a temporary 50- 60% improvement with previous lumbar steroid epidural injections. He noted the pain gradually returned after two weeks post-injection. Pre-operative evaluations, diagnostic studies, surgical intervention of the lumbar spine, equipment and a two day hospital stay were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral laminectomy L4-5 and lami right sided with resection of facet cyst L5-S1 placement of Coflex interspinous stabilization device: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(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. 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: Bilateral laminectomy L4-5 and lami right sided with resection of facet cyst L5-S1 placement of Coflex interspinous stabilization device is not medically necessary and appropriate.

Associated surgical service: 1-2 day inpatient 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.

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.

Pre-op clearance consultation: 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 labs: 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 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.

Pre-op EKG: 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: TEC system (Iceless cold therapy unit with DVT and Lumbar wrap): 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 requested treatment: Bilateral laminectomy L4-5 and lami right sided with resection of facet cyst L5-S1 placement of Coflex interspinous stabilization device is NOT Medically necessary and appropriate, then the Requested Treatment: Associated surgical

service: TEC system (Iceless cold therapy unit with DVT and Lumbar wrap) is NOT Medically necessary and appropriate.