

Case Number:	CM15-0102836		
Date Assigned:	06/05/2015	Date of Injury:	05/04/2011
Decision Date:	07/09/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	05/28/2015

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 54 year old male who sustained an industrial injury on 05/04/2011 resulting in upper, mid and low back pain/injury as well as bilateral leg and right foot. Treatment provided to date has included physical therapy, conservative therapies, injections and medications. Diagnostic tests performed include MRI of the lumbar spine (10/2014) showing right sided lateral recess and foraminal stenosis at L5-S1, large disc extrusion, and grade 1 spondylolisthesis at L5-S1 with collapse of 80%; electromyography and nerve testing confirmed S1 radiculopathy. Other noted dates of injury documented in the medical record include 1989, 1991 and 2006. There were no noted comorbidities. On 04/28/2015, physician consultation report noted complaints of axial low back pain with radiating pain to the right posterior thigh and calf to plantar and lateral foot. There was no pain rating or description of the injured worker's low back pain. Additional complaints include cramps at night, constant headaches, and radiating pain to the medial scapula. The physical exam of the lumbar spine revealed normal inspection and palpation of the lumbar spine; no erythema, swelling deformity or tenderness; healed midline incision; normal lordosis; normal range of motion; and normal muscle strength except for slightly decreased right posterior tibialis and gastroc (4-/5). The provider noted diagnoses of lumbar radiculopathy in this post laminectomy syndrome patient who has had 2 prior L5-S1 microdiscectomies, now with recurrent disc extrusion at L5-S1 and grade I lumbar spondylolisthesis. Other diagnoses include intervertebral disc displacement unspecified, acquired spondylolisthesis, post lumbar laminectomy syndrome, and lumbar radiculitis. Plan of care includes an L5-S1 anterior discectomy and instrumented arthrodesis and posterior decompression and instrumented arthrodesis. The injured worker agrees to the plan

for surgical intervention. Requested treatments include an L5-S1 anterior discectomy and instrumented arthrodesis and posterior decompression and instrumented arthrodesis, 3 day inpatient stay, 3-in-1 commode purchase, front wheeled walker purchase, lumbar brace purchase, and assistant surgeon.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 Anterior Discectomy and instrumented arthrodesis and posterior decompression & instrumented arthrodesis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305,307.

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: L5-S1 Anterior Discectomy and instrumented arthrodesis and posterior decompression and instrumented arthrodesis is NOT Medically necessary and appropriate.

Associated surgical services: LOS: Inpatient 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.

Post-Op DME purchase: 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-Op DME purchase: front wheeled 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.

Post-Op DME purchase: lumbar 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 services: 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.