

Case Number:	CM15-0103707		
Date Assigned:	06/08/2015	Date of Injury:	01/15/2014
Decision Date:	07/10/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	05/29/2015

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:

This 46 year old man sustained an industrial injury on 1/15/2014 when he was carrying heavy sheetrock. He had complaints of right shoulder, elbow, and numbness in left leg. Diagnoses included right shoulder SLAP tear with repair. Treatment has included oral medications, lumbar epidural steroid injections and surgical intervention for his shoulder. PR2 of 4/30/15 indicates when seen on 3/9/15 the patient had complaints of primarily axial back pain with some radicular left leg pain. Electrodiagnostic studies indicated a left lumbosacral radiculopathy more prominent at the L5 with possible bilateral S1 radiculopathy. MRI scan of 04/9/14 showed a bulging lumbar disc with facet hypertrophy and moderate to severe right neural foraminal narrowing. Physician notes dated 4/8/2015 showed complaints of right shoulder weakness and limited range of motion post-operatively. The worker rates his pain 2/10. Recommendations include continue rehabilitation for one month, then likely find him at maximum medical improvement, and follow up in four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5, L5-S1 interlaminar decompression and stabilization with coflex devices: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Online Version Dynamic neutralization system (Dynesys).

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. Documentation does not provide any evidence of instability. 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: L4-5, L5-S1 interlaminar decompression and stabilization with coflex devices is NOT Medically necessary and appropriate.

Associated surgical service: inpatient stay x1-2 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.

Orthopedic 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-operative history and physical: 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.