

Case Number:	CM15-0106616		
Date Assigned:	06/11/2015	Date of Injury:	12/13/2001
Decision Date:	07/14/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	06/02/2015

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 59 year old male sustained an industrial injury on 12/13/01. He subsequently reported low back pain. Diagnoses include spinal stenosis, radiculitis, lumbar spondylosis and degenerative disc disease. Treatments to date include x-ray and MRI testing, back surgery, physical therapy and prescription pain medications. The injured worker continues to experience low back pain. Upon examination, tenderness is noted over the paraspinals with related muscle spasms and myofascial restrictions. Lumbar range of motion is reduced. Straight leg raise produces low back pain bilaterally without radicular symptoms. A request for L4-5 Arthrodesis, Posterior Interbody Technique, including Laminectomy and or Discectomy qty 1, Application of Intervertebral Biomechanical device(S) (EG, synthetic cage(s), qty 2.00, L4-5 Posterior Segmental Fixation qty 1.00, Autograft for spine surgery only (includes harvesting the graft) qty: 1.00, CT scan L2-S1 qty 1 and Inpatient stay, # days qty 3 was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 Arthrodesis, Posterior Interbody Technique, including Laminectomy and or Discectomy qty 1: 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. Documentation notes no instability on recent lumbar x-rays. The requested treatment: L4-5 Arthrodesis, Posterior Interbody Technique, including Laminectomy and or Discectomy qty 1 is NOT Medically necessary and appropriate.

Associated surgical service: Application of Intervertebral Biomechanical device(S) (EG, synthetic cage(s), qty 2.00: 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: L4-5 Posterior Segmental Fixation qty 1.00: 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: Autograft for spine surgery only (includes harvesting the graft) qty: 1.00: 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: CT scan L2-S1 qty 1: 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, # days qty 3: 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.