

Case Number:	CM15-0130122		
Date Assigned:	07/20/2015	Date of Injury:	04/21/2013
Decision Date:	08/18/2015	UR Denial Date:	06/11/2015
Priority:	Standard	Application Received:	07/06/2015

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 57 year old male with an industrial injury dated 04/21/2013. The injured worker's diagnoses include spondylolisthesis at L4-L5 with instability, post laminectomy syndrome at L5-S1, with prior attempted fusion posteriorly only in 1980's, bilateral nerve root impingement at L5, radiculopathy and radiculitis in the bilateral lower extremities, recurrent bilateral leg pain worsening since the industrial injury, foraminal stenosis, moderate to severe at left L4-5, greater on the right side and post laminectomy syndrome at L5-S1 laminotomy/laminectomy in 1982. Treatment consisted of Magnetic Resonance Imaging (MRI) of the lumbar spine dated 07/18/2013, X-ray of lumbar spine dated 12/27/2013, Electromyography (EMG)/Nerve conduction velocity (NCV) study dated 10/16/2014, computed tomography scan of the lumbar spine dated 03/30/2015, physical therapy, activity modifications, epidural injections, facet injection, left hip injection, prescribed medications, and periodic follow up visits. In a progress note dated 06/04/2015, the injured worker reported worsening pain and leg pain bilaterally. The injured worker also reported leg pain, numbness and weakness despite conservative care for more than a year and a half. Objective findings revealed antalgic gait due to left leg pain, pain to palpitation over the L4-S1 area with palpable muscle spasms, limited range of motion secondary to pain, diminished sensation in the left worse than the right lower extremity in the L5 and S1 distribution and positive bilateral straight leg raises. The treating physician prescribed services for anterior / posterior L4-5, L5-S1 Lumbar Fusion, Discectomy, Decompression & instrumentation with neuromonitoring, preoperative medical clearance, and associated surgical services: two assistant surgeons, seven day inpatient stay, LSO lumbar brace and bone growth stimulator, now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior L4-5, L5-S1 Lumbar Fusion, Discectomy, Decompression & Instrumentation with Neuromonitoring; Posterior L4-5, L5-S1 Lumbar Fusion, Discectomy, Decompression & Instrumentation with Neuromonitoring: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers Comp, 20th Edition, 2015 Updates: Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Spinal Fusion Chapter-Spinal fusion-Patient selection criteria for lumbar spinal fusion-Instability criteria.

Decision rationale: The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had a vertebral fracture or dislocation. The movement the provider attests to be 3-4mm does not meet the criteria for instability in the ODG guidelines of greater than 4.5 mm. The California MTUS guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Anterior L4-5, L5-S1 Lumbar Fusion, Discectomy, Decompression & Instrumentation with Neuromonitoring; Posterior L4-5, L5-S1 Lumbar Fusion, Discectomy, Decompression & Instrumentation with Neuromonitoring is not medically necessary and appropriate.

Associated surgical service: Two assistant surgeons: 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: Seven 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.

Preoperative 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.

Associated Surgical Service: LSO 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 Service: 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.