

Case Number:	CM15-0181717		
Date Assigned:	09/23/2015	Date of Injury:	01/20/2014
Decision Date:	11/03/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	09/15/2015

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, Montana
 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 41 year old female, who sustained an industrial injury on 1-20-2014. The medical records indicate that the injured worker is undergoing treatment for lumbar sprain-strain, displaced lumbar intervertebral disc, thoracic or lumbosacral neuritis or radiculitis, and sciatica. According to the progress report dated 8-26-2015, the injured worker presented with complaints of low back pain with radiation into her left hip and leg. The level of pain is not rated. The physical examination of the lumbar spine reveals antalgic gait, motor weakness along left S1 dermatome, decreased sensory along the left L5 dermatome, restricted (15-25 degrees) and painful range of motion in all planes, and positive straight leg raise test at 35 degrees along the left L5 and S1 dermatomes. The current medications are Norco, Tramadol, and Naproxen. Previous diagnostic studies include MRI. MRI of the lumbar spine from 7-31-2015 showed lumbar spondylosis L4-5 and L5-S1 disc and 3 millimeter posterior osteophyte disc complex at L5-S1. Treatments to date include medication management and physical therapy. Work status is described as permanent and stationary. The original utilization review (9-10-2015) had non-certified a request for L5-S1 lumbar posterior interbody decompression, fusion allografting and repairs with all associated services.

IMR ISSUES, DECISIONS AND RATIONALES

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

One L5-S1 lumbar posterior interbody decompression, fusion allografting and repairs:
Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.
Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s):
Surgical Considerations.

Decision rationale: The California MTUS guidelines recommend lumbar surgery if there is severe persistent, debilitating lower extremity complaints, clear clinical and imaging evidence of a specific lesion corresponding to a nerve root or spinal cord level, corroborated by electrophysiological studies which is known to respond to surgical repair both in the near and long term. Documentation does not provide this evidence. California MTUS guidelines also recommend lumbar fusion if the patient has had a fracture, dislocation or evidence of significant instability. This is not the case. The requested treatment: One L5-S1 lumbar posterior interbody decompression, fusion allografting and repairs is not medically necessary and appropriate.

Associated surgical services: Assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 (CBC, BMP, UA, PT and PTT): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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: 3 Three to four day hospital stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 physical therapy 3x3: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

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.

Ultracet 37.5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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.