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| Case Number: | CM15-0194295 | | |
| Date Assigned: | 10/08/2015 | Date of Injury: | 12/02/2013 |
| Decision Date: | 12/03/2015 | UR Denial Date: | 09/18/2015 |
| Priority: | Standard | Application Received: | 10/02/2015 |

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, Montana, California
 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 59 year old male with a date of injury on 12-02-2013. The injured worker is undergoing treatment for spinal stenosis with spondylolisthesis at L4-5. Comorbid diagnoses include diabetes and hypertension. A physician progress note dated 08-21-2015 documents "the injured worker clinically does not so much present with peripheral neuropathic type symptoms as he does with back pain associated with claudication and limits to on average about 100 yards of ambulation. He has not had any epidural steroid injections and does not want to really go through with that procedure." Treatment to date has included diagnostic studies, medications, physical therapy. An Electromyography repost of the lower extremities show no evidence of abnormal Electromyography finding but evidence of abnormal nerve conduction velocity in the lower limbs. This could be compatible with severe peripheral neuropathy process which is axonal and demyelinating. A Magnetic Resonance Imaging of the lumbar spine done on 06-24-2015 shows diffuse degenerative disc disease, grade 3 spondylolisthesis L4 on L5, moderately severe stenosis at L4-5 which on the axial cuts is worse with lateral recess on the right side. The neural foramen is also impaired on the right side. Medications include Lyrica, Metformin, Atorvastatin, Glipizide and Lisinopril. On 09-18-2015 Utilization Review non-certified the request for Lumbar Open Decompression and Fusion at L4-L5 with Spinal Instrumentation and Iliac Crest Bone Graft, Assistant Surgeon, Post-Operative Physical Therapy (12-sessions, 2 times a week for 6-weeks), Associated Surgical Service: Aspen Quick Draw Back Brace, and Inpatient Stay (3-days).

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Open Decompression and Fusion at L4-L5 with Spinal Instrumentation and Iliac Crest Bone Graft: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th Edition (web) 2014, Low Back, Indications for Surgery, Discectomy/Laminectomy/Fusion (spinal).

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

Decision rationale: California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of these conditions. Documentation is not provided to show movement or progression at the level of the anterolisthesis. While the patient has symptoms of neurogenic claudication, e.g. decreased walking tolerance at distance, he is not presenting with a radiculopathy but with back pain. The California MTUS guidelines do recommend lumbar surgery if there is clear clinical, electrophysiological and imaging evidence of specific nerve root or spinal cord level of impingement which would correlate with severe, persistent debilitating lower extremity pain unresponsive to conservative management. Documentation does not provide this evidence. The requested treatment: Lumbar Open Decompression and Fusion at L4-L5 with Spinal Instrumentation and Iliac Crest Bone Graft is not medically necessary and appropriate.

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.

Inpatient Stay (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-Operative Physical Therapy (12-sessions, 2 times a week for 6-weeks): 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: Aspen Quick Draw Back 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.