

Case Number:	CM15-0221949		
Date Assigned:	11/18/2015	Date of Injury:	11/14/2011
Decision Date:	12/30/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	11/11/2015

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 47 year old female, who sustained an industrial injury on 11-14-2011. The injured worker was being treated for lumbar radiculopathy. Treatment to date has included diagnostics, physical therapy, epidural injections, and anti-inflammatory medications. On 9-29-2015, the injured worker complains of low back pain, as well as neck pain and numbness in her hands predominant complain was low back pain, rated 8 out of 10. She reported difficulty holding her urine for the past 6 months. Function with activities of daily living was not described. A review of symptoms noted depression and frequent urination at night and past medical history included diabetes. Medication was "as needed for pain", unspecified. Exam of the lumbar spine noted tenderness to palpation over the paraspinal musculature, lower extremity strength 5 of 5 bilaterally, and diminished sensation over the bilateral L4 dermatomes. Magnetic resonance imaging of the lumbar spine was documented as showing L3 to L5 stenosis. Magnetic resonance imaging of the lumbar spine report (2-19-2015) was submitted and showed L3-4: 3-4mm posterior disc bulge with focal disc extrusion traveling 7mm in a cranial direction resulting in moderate right neural foraminal narrowing and moderate canal stenosis. Right exiting nerve root compromise is seen. L4-5: posterior annular tear is seen within the intervertebral disc. 2-3mm posterior disc bulge resulting in mild to moderate left and moderate to severe right neural foraminal narrowing in conjunction with facet joint hyoertrophy. Mild canal stenosis is seen, Bilateral exiting nerve root compromise is seen. L5-S1: 1-2mm posterior disc bulge without evidence of canal stenosis or neural foraminal narrowing. She was prescribed Ultram for flare-up episodes and Omeprazole for gastritis. She remained off work. The treatment plan included L3- L5 decompression and fusion and associated services, non-certified by Utilization Review on 10- 20-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-L5 Decompression and Fusion: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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. The California MTUS guidelines recommend lumbar 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. 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. Documentation is not provided to support these concerns. The requested treatment: L3-L5 Decompression and Fusion is not medically necessary and appropriate.

3 day in patient 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.

Pre-op 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.

Pre-op Labs: Chemistry Panel: 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-op Labs: CBC: 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-op Labs: PT/INR: 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-op Labs: UA: 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-op EKG: 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-op Chest X-ray: Upheld

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-op Chest X-ray: 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-op physical therapy 2 times a week for 8 weeks for the lumbar spine: 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.