MAXIMUS Federal Services

Case Number:	CM15-0032524		
Date Assigned:	03/26/2015	Date of Injury:	04/21/2014
Decision Date:	05/01/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/20/2015

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 35 year old female, date of injury, April 21, 2014 fell off a cement wall while putting up an umbrella. The injured worker landed on a planter on her bottom. She reported pain in her lower back. Her MRI of the lumbar spine on 06/20/14 was reported by the radiologist as showing a degenerative disc space and circumferential disk osteophyte complex with minimal mass effect on the left S1 nerve root and no canal or neural foraminal narrowing. The provider on the other hand diagnosed a large Left L5-S1 herniated disk. A selective LS1 nerve root block on 12/11/14 gave no relief. The injured worker was diagnosed by the provider as having lumbosacral sprain/strain, L5-S1 lumbar disc derangement and left lumbar radiculopathy. Treatment to date has included diagnostic studies, surgery, physical therapy and medications. On January 7, 2015, the injured worker complained of pain radiating from the lower back to the left lower extremity that is associated with numbness and tingling in the left leg. The pain was noted to not be tolerable and was increased enough for surgery according to the provider. Physical examination revealed positive lumbar tenderness and muscle spasms in the paraspinal musculature. Lumbar spine range of motion was noted to be decreased about 30%. Straight-leg raise and bowstring were positive on the left. The treatment plan included surgery, post-surgical care and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Lumbar Discectomy and Fusion (ALDF) L5-S1 with Allograft Cage and Plate: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Low Back Disorders (revised 2007), pages 209-211 and Official Disability Guidelines, Lumbar Fusion, Discectomy/Laminectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305 and 307.

Decision rationale: The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation shows this patient has been complaining of pain in the lower back. Documentation does not disclose disabling symptoms. The guidelines also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The requested treatment is for an anterior lumbar discectomy and fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. 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. Documentation does not show instability. The requested treatment: Anterior Lumbar Discectomy and Fusion (ALDF) L5-S1 with Allograft Cage and Plate is NOT Medically necessary and appropriate.

Anterior Lumbar Arthrodesis including diskectomy and lateral retroperitoneal approach technique: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Low Back Revision (2007), pages 202-204.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305 and 307.

Decision rationale: The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation shows this patient has been complaining of pain in the lower back. Documentation does not disclose disabling symptoms. The guidelines also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The requested treatment is for an anterior lumbar discectomy and fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. 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. Documentation does not show

instability. The requested treatment: Anterior Lumbar Arthrodesis including Discectomy and lateral retroperitoneal approach technique is NOT Medically necessary and appropriate.

Associated surgical service: Inpatient Stay x 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.

Associated surgical service: 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.

Pre-Operative Medical Clearance Evaluation: 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: Hot/Cold Therapy Unit: 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: Muscle 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.

Associated surgical service: LSO 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.

Post-Operative Physical Therapy 2 x 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.