

Case Number:	CM15-0039363		
Date Assigned:	04/09/2015	Date of Injury:	01/27/2014
Decision Date:	05/01/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	03/02/2015

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

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 male who sustained an industrial injury on 1/27/14 after reaching and pulling resulting in sudden onset of stabbing back pain and lumbar swelling. There has been no improvement in pain since the accident. He had a prior back injury 15 years ago. He currently complains of bilateral back pain with radiation to the anterior thighs and paresthesia on bilateral calves. He also complains of daily groin and saddle burning pain. His pain intensity is 9/10. He is experiencing bladder problems as well. His activities of daily living are limited. Medications are Norco, Ambien, Lyrica, Cyclobenzaprine, and Ibuprofen. Diagnoses include lumbosacral disc degeneration; bilateral lower extremity radiculitis; sciatica; stenosis; herniated nucleus pulposus with myelopathy, lumbar; chronic pain disorder; depression. Treatments to date include L5 transforaminal epidural steroid injection (3/20/14) without relief; medications; heat and physical therapy without improvement. Diagnostics include MRI of the lumbar spine (1/28/14) revealing disc protrusion, foraminal narrowing; x-rays of lumbar spine (no date). In the progress note dated 1/22/15 the treating provider's plan of care indicates no improvement with conservative treatment. Due to significant back pain and lower extremity radiating pain due to multi-level stenosis the recommendation is for L3-S1 laminectomy and posterior spinal instrumented fusion with transforaminal posterior lumbar inter-body fusion at L4-5 and L5-S1 to restore lordosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior spinal fusion, laminectomy L3-S1, interbody fusion L4-S1, with instrumentation, PEEK spacers, BMP, possible iliac crest bone graft with 3 day inpatient stay: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: 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. 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 a posterior spinal fusion, lumbar laminectomy and interbody fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: Posterior spinal fusion, laminectomy L3-S1, interbody fusion L4-S1, with instrumentation, PEEK spacers, BMP, possible iliac crest bone graft with 3 day inpatient stay is not medically necessary and appropriate.

Surgical assistant: Upheld

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

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, CMP, PTT, PT/INR, UA, Nares Culture for MRSA: Upheld

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

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: Lumbar brace, DJO bone growth stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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.