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| Case Number: | CM15-0042544 | | |
| Date Assigned: | 03/12/2015 | Date of Injury: | 12/09/2013 |
| Decision Date: | 04/20/2015 | UR Denial Date: | 02/20/2015 |
| Priority: | Standard | Application Received: | 03/06/2015 |

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 39 year old male, who sustained an industrial injury on 12/09/2013. He was diagnosed as having lumbar herniated disc, lumbar stenosis and lumbar instability. Treatment to date has included magnetic resonance imaging (MRI), medications, injections, and physical therapy. Per the Primary Treating Physician's Progress Report dated 2/09/2015, the injured worker reported severe low back and bilateral leg pain, left more than right. The pain is rated as 8-9/10 and he reports that he cannot sleep. Physical examination revealed a positive straight leg raise test bilaterally with generation of severe low back pain plantarflexors and dorsiflexors are quite weak, rated as 3+/5 bilaterally. This is due to severe paraspinal muscle spasms. He is walking with a cane and is quite apprehensive. The plan of care included surgical intervention. Authorization was requested for anterior and posterior L4-S1 fusion and decompression, and postoperative medical equipment including a back brace, bone stimulator and cane.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior and posterior L4-S1 fusion and decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

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

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 California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling symptoms if there is clear clinical, imaging and electrophysiological correlation. The documentation shows this patient has been complaining of pain in the lower back, legs, neck and upper back. Documentation does not disclose disabling shoulder and arm 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 and posterior L4-S1 fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. Moreover, the patient's flagrant pain behavior should be a major red flag against consideration of a surgical approach to this patient's complaints. Documentation shows he got no improvement from the lumbar ESI's and showed no improvement from physical therapy which he described as worthless. The requested treatment anterior and posterior L4-S1 fusion and decompression is not medically necessary and appropriate.

Post-operative Back Brace purchase: 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 bone stimulator purchase: 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 purchase of a cane: 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 length of stay of two 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.