MAXIMUS Federal Services

Case Number:	CM15-0046431		
Date Assigned:	03/18/2015	Date of Injury:	10/03/2002
Decision Date:	05/01/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	03/11/2015

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
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 55 year old male, who sustained an industrial injury on 10/03/2002. Initial complaints reported included left knee pain. The injured worker was diagnosed as having re-torn left meniscus. Treatment to date has included conservative care, medications, lumbar laminectomy (x2), x-rays of the lumbar spine, MRI of the lumbar spine (11/18/2014), lumbar epidural steroid injections, consultations, left knee surgery (x2), physical therapy, chiropractic manipulation, and psychotherapy/psychiatric treatment. Currently, the injured worker complains of 2 recent flare-ups of low back pain. Current diagnoses include displacement of lumbar intervertebral disc without myelopathy, degeneration of lumbar intervertebral disc, degeneration of intervertebral disc, lumbar post-laminectomy syndrome, lumbar sprain, enthesopathy of the hip regions, patellar tendinitis, current tear of medial cartilage and/or meniscus of knee, morbid obesity, and localized primary osteoarthritis. The treatment plan consisted of laminectomy/ discectomy/fusion of the L5-S1, transforaminal lumbar interbody fusion with posterolateral pedicles screw fusion assisted by surgical assistant with a 3 day inpatient stay, pre-operative clearance for history and physical, pre-op EKG and laboratory testing, and post-operative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Laminectomy/Diskectomy/Fusion at L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-308.

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 his knees, neck, shoulders, hip, legs and feet with sexual dysfunction. Documentation does not disclose disabling radiculopathy 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 a laminectomy/diskectomy/fusion L5-S1. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The PR2 of 12/1/2014 notes there is no evidence of spondylolisthesis or spondylolysis. The requested treatment: Laminectomy/diskectomy/fusion at L5-S1 is not medically necessary and appropriate.

Transforaminal lumbar interbody fusion with posteriolateral pedicle screw fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-308.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305 and307.

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 his knees, neck, shoulders, hip, legs and feet with sexual dysfunction. Documentation does not disclose disabling radiculopathy 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 a laminectomy/diskectomy/fusion at L5-S1. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The PR2 of 12/1/2014 notes there is no evidence of spondylolisthesis or spondylolysis. The requested treatment: Transforaminal lumbar interbody fusion with posteriolateral pedicle screw fusion is not medically necessary and appropriate.

Associated surgical service: Length of stay: inpatient x3 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: Surgical assistant: PA: 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 clearance for H&P: 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 labs (not specified): 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 x12 to 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.