

Case Number:	CM15-0055378		
Date Assigned:	04/15/2015	Date of Injury:	12/20/2006
Decision Date:	05/08/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	03/23/2015

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 63 year old male, who sustained an industrial injury on 12/20/2006. The current diagnoses are thoracic/lumbosacral neuritis, lumbar spinal stenosis with neurogenic claudication, kyphoscoliosis/scoliosis, and post laminectomy syndrome of the lumbar region. According to the progress report dated 1/19/2015, the injured worker complains of worsening pain, bilateral leg heaviness, numbness of toes; lumbosacral pain with radiation to bilateral buttocks and anterolateral calf. The current medications are Naproxen, Prilosec, Cyclobenzaprine, and Norco. Treatment to date has included medication management, MRI studies, physical therapy, pain injections, and surgical intervention. The plan of care includes L3-4 right L4-5 decompression laminectomy with instrumentation from T9-S1 with Smith Peterson osteotomies T12, L1, L2, surgical assistant, 5 day inpatient stay, bone growth stimulator, front wheeled walker, lumbar brace, cardiology clearance, and nursing facility times 2 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-4 Right L4-5 Decompression Lami with instrumentation from T9-S1 with Smith Peterson osteotomies T12, L1, L2, Inpatient 5 days and Surgical Assistant: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Work Loss Data Institute, www.odg-twc.com; Section: Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 1/30/2015).

MAXIMUS guideline: Decision based on MTUS ACOEM 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 lower extremity symptoms. The documentation shows this patient has been complaining of pain in the back. Documentation does not disclose disabling lower extremity 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 lumbar decompression with instrumentation and osteotomies which will result in fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: L3-4 Right L4-5 Decompression Lami with instrumentation from T9-S1 with Smith Peterson osteotomies T12, L1, L2, Inpatient 5 days and Surgical Assistant is not medically necessary and appropriate.

Associated surgical services: Bone Growth 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: Front Wheel Walker: 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: :Lumbar 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-op Skilled Nursing Facility x 2 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.

Associated surgical service: Cardiology 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.