

Case Number:	CM15-0055785		
Date Assigned:	04/01/2015	Date of Injury:	05/28/2009
Decision Date:	05/06/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/24/2015

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 57 year old male on May 28, 2009 twisted his low back and was knocked to his left side while using a pressurized pneumatic gun. He reported low back pain and left lower extremity tingling and numbness. The injured worker was diagnosed as having radiculopathy of the left lower extremity, lumbar and sacral disc herniation, depression and anxiety and weakness of the left lower extremity. Treatment to date has included activity modification, observation, physical therapy, lumbar ESIs, chiropractic care, therapeutic lumbar acupuncture, medications and work restrictions. Currently, the injured worker complains of lumbar pain with left lower extremity radiculopathy symptoms. On 04/09/13 electrodiagnostic studies showed a chronic L5 radiculopathy. MRI scan of 07/25/14 showed a broad based disc bulge at L5-S1. He was treated conservatively without complete resolution of the pain. The PR2 of 08/14/2014 indicated after physical therapy he felt 40% improved, felt less pain, could stand and walk longer and had discontinued Norco. Evaluation on 01/06/2014 showed anatomically unchanged ossified lumbar disc extrusion at L5-S1 on the left. His ankle reflexes were absent and he had a weak left extensor hallucis longus. Evaluation on January 29, 2015, revealed continued pain, but a normal gait, and unremarkable motor examination. Surgical intervention was requested and had been noted to be recommended as early as January of 2013 the first time. Requests also included pre-operative clearance, surgical assistance and radiographic imaging.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Transforaminal Lumbar Interbody Fusion at L5-S1 with interbody peek cages, Bone Marrow Aspiration, Bone Graft substitute and Pedicle Screw Fixation: Upheld

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

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 at L5-S1. 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 and leg. 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 interbody fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: Bilateral Transforaminal Lumbar Interbody Fusion at L5-S1 with interbody peek cages, Bone Marrow Aspiration, Bone Graft substitute and Pedicle Screw Fixation is not medically necessary and appropriate.

Associates Surgical Services: Assistant Surgeon for the proposed surgery: Upheld

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

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.

Associates Surgical Services: 1 Day Stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter regarding Length of Stay.

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: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 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.

MRI of the Lumbar Spine: Upheld

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

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.