

Case Number:	CM15-0059072		
Date Assigned:	04/03/2015	Date of Injury:	05/14/2002
Decision Date:	05/05/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	03/27/2015

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 46-year-old female occupational therapist fell backward from a chair on May 14, 2002. She reported neck and low back pain. The diagnoses have included cervical disc syndrome, thoracic disc syndrome, lumbar disc syndrome, impingement syndrome on the left, somatic symptoms disorder with predominant pain and major depressive disorder. Treatment to date has included medications, radiological studies, electrodiagnostic studies, chiropractic care, psychological evaluations, anterior cervical spine surgery and right shoulder surgery. Most current documentation dated January 19, 2015 notes that the injured worker reported intractable back pain with radiation to the left lower extremity with associated numbness and tingling. Severity of symptoms was described as moderate to severe with profound limitations. The injured worker also reported left shoulder pain. No objective findings were noted. The treating physician's plan of care included a request for an anterior lumbar interbody fusion at L5-S1, preoperative clearance, inpatient stay for 2-3 days, assistant surgeon, post-operative back brace, post-operative walker and post-operative physical therapy 3 times a week for 6 weeks to the lumbar spine. Her lumbar MRI scan did not report any ruptured lumbar discs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Lumbar Interbody Fusion at L5-S1, L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

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 lower extremity symptoms. The documentation shows this patient has been complaining of pain in the neck, shoulder and 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 patient's lumbar MRI scan notes a diffuse disc bulge at L5-S1 and does not list lumbar disc herniations. The requested treatment is for an anterior lumbar interbody fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. Therefore, the request is not medically necessary and appropriate

Pre-Operative 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.

Inpatient Stay (2-3 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.

Assistant surgeon: 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 Back 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-Operative 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.

Post-Operative Physical Therapy (18-sessions, 3 times a week for 6 weeks to the 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.