

Case Number:	CM15-0082492		
Date Assigned:	05/04/2015	Date of Injury:	09/01/2012
Decision Date:	08/05/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	04/29/2015

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 was a 24 year old female, who sustained an industrial injury, September 1, 2012. The injured worker previously received the following treatments discogram, Norco, Flector Patches, Gralise, Cyclobenzaprine, Abilify, Trazodone, Prozac and lumbar spine MRI. The injured worker was diagnosed with chronic intractable pain, moderate facet arthropathy L3-L4, L4-L5 and L5-S1, disc degeneration of L4-L5 lateral recess and frontal stenosis of L4-L5 and bilateral L4 radiculopathy. According to progress note of April 9, 2015, the injured workers chief complaint was low back pain, around the area of L4-L5, with intermittent leg pain radiating into the anterior and medial thighs ending at the knees. The injured worker rated the pain at 6 out of 10 with pain medication and increased to an 8 out of 10 without medication; 0 being no pain and 10 being the worse pain. The physical exam noted tenderness centrally over the L4-L5 level, primarily on the left. There was decreased sensation at the right L4 dermatome distribution. The treatment plan included L4-L5 laminectomy and Subtotal facetectomy, inpatient stay, postoperative physical therapy, pneumatic intermittent compression device and cold therapy unit rental for 30 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 laminotomy, subtotal facetectomy, transforaminal lumbar interbody fusion and posterior spinal: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306, 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back summary online version.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-7.

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 guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: L4-5 laminotomy, subtotal facetectomy, transforaminal lumbar interbody fusion and posterior spinal is NOT Medically necessary and appropriate.

Associated surgical service: 4 days inpatient stay: 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 physiotherapy 3x6: 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: Pneumatic intermittent compression device: 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: Cold therapy unit rental x 30 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.