

Case Number:	CM15-0108143		
Date Assigned:	06/12/2015	Date of Injury:	12/19/2014
Decision Date:	07/14/2015	UR Denial Date:	05/29/2015
Priority:	Standard	Application Received:	06/04/2015

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 53 year old male who sustained a work related injury December 19, 2014. Past history included upper gastrointestinal bleeding 2007 and 2009. While lifting heavy boxes, he developed low back pain which radiated over both buttocks, posterior calves and into the feet. An x-ray and MRI of the lumbar spine, dated January 29, 2015 (report present in medical record) were performed and he received medication and physical therapy. Diagnosis is documented as lumbar disc disease with radiculopathy. According to a primary treating physician's progress report, dated May 11, 2015, the injured worker presented with ongoing lower back pain, rated 5-7/10. He has an established diagnosis of L5-S1 discopathy with a 6mm x 3mm posterior disc protrusion primarily on the right side compressing the left S1 nerve root and bilateral sciatica in the L5-S1 distribution, left greater than right. Examination of the lumbosacral spine revealed; pain in the lumbosacral junction at the level of the herniated disc, straight leg raise positive on the left and slightly positive on the right, increased with dorsiflexion of the foot and ankle. There is decreased sensation in the L5-S1 distribution to pinprick and light touch. Treatment plan included; at issue, a request for lumbar fusion, a 3 day hospital stay, one office visit, and a corset brace. A posterior lumbar decompression and discectomy L5-S1, assistant for surgery, and medical clearance were authorized.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar fusion: Upheld

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

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 guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested Treatment: Lumbar fusion is not medically necessary and appropriate.

Associated surgical service: 3 day hospital 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.

Associated surgical service: One office visit: 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: corsette 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.