

Case Number:	CM15-0113298		
Date Assigned:	06/19/2015	Date of Injury:	11/18/2013
Decision Date:	07/22/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	06/11/2015

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(n) 46 year old female, who sustained an industrial injury on 11/18/13. She reported injuring her left lower back while mopping. The injured worker was diagnosed as having lumbar degenerative disc disease, central left-sided disc herniation at L5-S1 and persistent back pain with left lower extremity radiculopathy. Treatment to date has included a lumbar MRI on 2/12/15 showing a left-side disc herniation at L5-S1, a lumbar epidural injection and myelography at L5-S1 on 10/20/14, physical therapy and chiropractic treatments. On 9/18/14, the injured worker reported her pain with intensifying and she is having difficulty doing light-duty activities at her job. As of the PR2 dated 4/21/15, the injured worker reports moderate back pain that radiates down her left leg. Objective findings include a positive straight leg raise test bilaterally, a left antalgic type gait and difficulty in toe walking due to weakness. The treating physician requested an anterior L5-S1 lumbar interbody fusion w/ instrumentation and posterior L5-S1 lumbar laminectomy / laminectomy, a co-vascular surgeon, a pre-op consult, a hot/cold therapy unit with wrap, a lumbar brace and an assistant surgeon.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery: Anterior L5-S1 Lumbar Interbody Fusion W/ Instrumentation and Posterior L5- S1 Lumbar Laminectomy / Laminectomy: 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. Documentation is not provided which supports instability. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Surgery: Anterior L5-S1 Lumbar Interbody Fusion W/ Instrumentation and Posterior L5-S1 Lumbar Laminectomy / Laminectomy is NOT Medically necessary and appropriate.

Associates Surgical Services: Co Vascular 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.

Pre Op Consult: 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.

Associates Surgical Services: DME: Hold/Cold Therapy Unit w/ wrap: 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.

Associates Surgical Services: DME: 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.

Associates Surgical Services: 3- 4 inpatient 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.

Associates Surgical Services: 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.