

Case Number:	CM15-0115243		
Date Assigned:	06/23/2015	Date of Injury:	05/11/2005
Decision Date:	07/27/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	06/15/2015

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 55 year old female, who sustained an industrial injury on 5/11/2005, from continuous trauma. The injured worker was diagnosed as having displacement of lumbar intervertebral disc without myelopathy. Treatment to date has included diagnostics, physical therapy, chiropractic, multiple lumbar epidural steroid injections, and medications. Currently, the injured worker complains of increasing back pain over the last few years, with radiation to lateral legs, right worse than left. She also reported mild to moderate weakness of her right leg. Current medications included Triamterene, Norco, Terazosin patches, and Cyclobenzaprine. Currently she was working part time, five hours per week. Exam of her low back noted moderate tenderness to palpation, moderate guarding in motion, mild to moderate difficulty rising from a seated to standing position, and normal gait. Muscle strength was 5/5, except in right ankle dorsiflexion at 4/5. Lower extremity sensation was decreased in the right L4-5 distribution. X-rays of the lumbar spine showed a 5mm L4-5 grade 1 spondylolisthesis, which increased to 6mm on flexion view. Magnetic resonance imaging (2/2015) showed anterolisthesis at L4 and L5, associated with severe bilateral facet arthropathy, as well as central canal narrowing. There was also right foraminal stenosis. The treatment plan included posterior decompression, fusion, and fixation at L4-5, with iliac crest bone graft, 2 day inpatient stay, pre-operative medical clearance (chest x-ray, labs, and electrocardiogram), Orthofix bone growth stimulator, and lumbar brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior decompression, fusion and fixation at L4-L5 with iliac crest bone graft: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305 - 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), as well as the American Medical Association Guidelines.

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. A Radiologist's report of instability on flexion and extension x-rays is not found in the documentation. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. Therefore, the request for posterior decompression, fusion and fixation at L4-L5 with iliac crest bone graft is not medically necessary and appropriate.

Associated surgical service: Two day 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.

Associated surgical service: Pre-operative medical clearance (CXR, labs, EKG): 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: OrthoFix bone growth stimulator (dispensed at [REDACTED]): 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: Lumbar brace (dispensed at [REDACTED]): 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.