

Case Number:	CM15-0115726		
Date Assigned:	06/29/2015	Date of Injury:	01/06/2014
Decision Date:	07/28/2015	UR Denial Date:	06/01/2015
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 36 year old male who sustained an industrial injury on 01/06/2014. The injured worker was diagnosed with lumbar lytic spondylolisthesis and left lower extremity radicular pain. Treatment to date has included diagnostic testing with lumbar spine magnetic resonance imaging (MRI) and electrodiagnostic studies, back brace, physical therapy and medications. According to the treating physician's progress report on February 9, 2015, the injured worker continues to experience low back pain. There was no physical or objective assessment documented. According to a previous primary treating physician's progress report on December 11, 2014, the injured worker rates his back pain at 3/10. Without Motrin his pain level is rated at 8/10 and goes down to 5/10 allowing him to work without restrictions. Examination demonstrated decreased range of motion with tenderness to the paraspinal muscles, left side greater than right side with positive Kemp's bilaterally. Straight leg raise was positive on the left at 45 degrees and negative on the right. There was normal strength and sensation on the right at L4, L5 and S1. There was normal strength on the left with decreased sensation at L4, L5 and S1. There was a slight impairment of the injured worker's gait. Current medication is listed as Motrin. Treatment plan consists of continuing with medication and the current request for surgical intervention with an anterior lumbar inter-body fusion with femoral ring allograft, bone morphogenic protein and posterior spinal fusion with longitude (Medtronic) instrumentation at L5-S1, 4 day in-patient hospital stay, assistant surgeon and pre-operative medical clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) anterior lumbar inter-body fusion with femoral ring allograft and bone morphogenic protein: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for lumbar spinal fusion.

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: One (1) anterior lumbar inter-body fusion with femoral ring allograft and bone morphogenic protein is not medically necessary and appropriate.

One (1) posterior spinal fusion with longitude (Medtronic) instrumentation at L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG,) Indications for Surgery, Discectomy); Low Back, Lumbar & Thoracic (Acute & Chronic), Fusion.

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: One (1) posterior spinal fusion with longitude (Medtronic) instrumentation at L5-S1 is not medically necessary and appropriate.

Associated surgical service: Four (4) days in-patient 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.

One (1) pre-op clearance with an internal medicine specialist: 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.

One (1) request for 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.