

Case Number:	CM15-0119153		
Date Assigned:	06/29/2015	Date of Injury:	11/08/2013
Decision Date:	07/30/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	06/19/2015

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 45 year old male with an industrial injury dated 11/08/2013. The injured worker's diagnoses include herniated nucleus pulposus at L5-S1. Treatment consisted of Magnetic Resonance Imaging (MRI) of lumbar spine, Electromyography (EMG) /Nerve conduction velocity (NCV), lumbar epidural steroid injection (ESI), prescribed medications, crutches and periodic follow up visits. In a progress note dated 04/03/2015, the injured worker reported constant low back pain and left leg pain with associated numbness and weakness. Objective findings revealed antalgic gait, tenderness to palpitation over lumbar spine and paraspinal area, limited range of motion with pain, decreased sensation in left lower extremity, and positive straight leg raises on the left. In an emergency department progress note dated 4/27/2015, the injured worker reported increased low back pain with radiculopathy down his left leg with some numbness and tingling. Physical exam revealed mild tenderness to palpitation of left lower lumbar musculature, straight leg raises on left and increasing pain with full flexion. Lumbar spine x-ray dated 4/27/2015 was unremarkable. The treating physician prescribed services for Posterior Decompression and Fusion L3-4, L4-5, L5-S1, pre-op Clearance by internal medicine, pre-op testing (UA, PT/PTT, CBC, EKG, Chest X-ray) and associated Surgical Service: 4-day inpatient hospital stay now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior Decompression and Fusion L3-4, L4-5, L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

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

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not supply this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. 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. Therefore, the request for posterior decompression and fusion L3-4, L4-5, L5-S1 is not medically necessary and appropriate.

Pre-op Clearance by internal medicine: 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 testing (UA, PT/PTT, CBC, EKG, Chest X-ray): 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: 4 day inpatient 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.