MAXIMUS Federal Services

Case Number:	CM15-0124599		
Date Assigned:	07/09/2015	Date of Injury:	08/20/2013
Decision Date:	08/05/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	06/29/2015

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 35 year old male who sustained an industrial injury on 8/20/13. The mechanism of injury is unclear. He currently complains of increased low back pain with intermittent bilateral radicular symptoms left greater than right with a pain level of 8/10. He has numbness in the legs and pain radiation to the hips. He has sleep difficulties. On physical exam of the lumbar spine there was tenderness on palpation with spasms, positive straight leg raise. Diagnoses include lumbar degenerative disc disease with radiculopathy at L5-S1; lumbar spine disc protrusion with radiculopathy at L5-S1; insomnia; lumbar sprain/ strain. Medications are Some, Anaprox, Prilosec, Norco, Xanax, cyclobenzaprine, topical creams. Treatments to date include band training at home; walking; medications. Diagnostics include MRI of the lumbar spine (12/3/14) showing spondylosis, disc bulge; x-ray of the lumbar spine (1/14/15) showing minimal degenerative disc disease. In the progress noted dated 6/15/15 the treating provider's plan of care includes requests for L4-5 and L5-S1 anterior/ posterior discectomy, decompression and fusion with instrumentation and allograft; basic metabolic panel; pre-operative medical clearance; post-operative physical therapy; lumbosacral brace; cold therapy unit; bone stimulator for purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 AND L5-S1 anterior/posterior discectomy, decompression and fusion with instrumentation and allograft: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter (updated 05/15/15) Discectomy/Laminectomy.

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

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 provide 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. The requested treatment: L4-L5 AND L5-S1 anterior/posterior discectomy, decompression and fusion with instrumentation and allograft is NOT Medically necessary and appropriate.

Associated surgical service: Preoperative medical clearance: 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: BMP (basic metabolic panel) laboratory test: 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: Postoperative physical therapy 3 times a week for 4 weeks: 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: 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: Cold therapy unit rental: 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: Bone stimulator purchase: 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.