

Case Number:	CM15-0126150		
Date Assigned:	07/17/2015	Date of Injury:	10/15/2013
Decision Date:	08/17/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	07/01/2015

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:

This injured worker is a 44 year old male who reported an industrial injury on 10/15/2013. His diagnoses, and or impression, were noted to include: degenerative lumbar disc disease with stenosis and radiculitis; lumbosacral disc herniation with bulging into the left side; discogenic low back pain; and sciatica. Magnetic imaging studies of the lumbar spine were done on 5/17/2015. His treatments were noted to include an agreed medical evaluation on 3/31/2015; an Emergency Room (ER) visits, with treatment, on 5/17/2015 for increased back pain; medication management; and rest from work. The progress notes of 5/1/2015 reported a follow-up to the 5/17/2015 Emergency Room visit for back pain, and complaints which included worsening lower back symptoms. Objective findings were noted to include the review of the magnetic resonance imaging studies taken during the ER visit which noted a large lumbosacral annular tear; significant pain with difficulty standing, even in a crouched gait; significant spasms in the lumbar spine with waist asymmetry; significant tenderness at the lumbosacral junction; and a much limited further examination due to pain, spasm and central lock of lumbar spine. The physician's requests for treatments were noted to include pre-operative medical clearance, and lumbosacral laminectomy and fusion surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Lumbar Interbody Fusion of L5-S1 with Posterior Laminectomy and Fusion:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, chapter 7.

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: Anterior Lumbar Interbody Fusion of L5-S1 with Posterior Laminectomy and Fusion is not medically necessary and appropriate.

Pre-Op 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.

Post-operative front-wheeled walker: 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.

Post-Op lumbosacral orthosis: 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.

Post-Op Physical Therapy, 2 times a week for 6 weeks to the Lumbar Spine: 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.