MAXIMUS Federal Services

Case Number:	CM15-0168827		
Date Assigned:	09/09/2015	Date of Injury:	09/04/2008
Decision Date:	11/02/2015	UR Denial Date:	07/30/2015
Priority:	Standard	Application Received:	08/27/2015

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, Montana
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 (IW) is a 54 year old male who sustained an industrial injury on 09-04-2008. He reported a slip and fall where he landed on his knees. The injured worker was diagnosed as having lumbosacral spondylosis, spinal stenosis lumbar, and Thoracic-lumbosacral neuritis-radiculitis. Treatment to date has included oral medications and epidural steroid injections X3. Currently, the injured worker complains of low back pain associated with right lower extremity pain radiating to his hamstring and calf. He describes the back pain as stabbing and constant. Sitting down worsens his symptoms, He has a decreased ability to sit and walk, but is able to stand without difficulty. On exam (06-12-2015) the right lower extremity range of motion is unremarkable, strength and tome are normal, and there was no tenderness palpated. The left lower extremity did not show any tenderness, deformity or injury and range of motion was unremarkable. The lower back had limited range of motion with right paraspinal tenderness without spasm. Lumbo sacral spine x-rays show significant spondylosis at the L4-5 and L5-S1 levels with no evidence of spondylolisthesis. A MRI of the lumbar spine shows evidence of a right L5-S1 synovial cyst and significant facet arthropathy. Significant facet arthropathy is noted at the L4-5 level also. He has significant right lower radicular complaint. He has a positive straight leg raise and an absent right ankle reflex. There are normal motor 5/5, no significant deficit in the neural exam, and no bowel or bladder dysfunction. A request for authorization was submitted for the following: 1. Anterior/posterior spinal fusion at L5-S1 with right L5-S1 laminotomy with neuromonitoring during surgery. 2. Preoperative surgical clearance. 3. Preoperative labs: PTT and INR. 4. Preoperative labs: metabolic panel. 5. Preoperative labs: UA. 6. Preoperative EKG. 7. Preoperative chest x-ray. 8. Preoperative labs: CBC. 9. Post-operative physical therapy x12 sessions, twice weekly for 6 weeks. A utilization review decision (07-30-2015) non-certified the request in its entirety.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior/posterior spinal fusion at L5-S1 with right L5-S1 laminotomy with neuromonitoring during surgery: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back- Indications for lumbar spinal fusion.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: The California MTUS guidelines recommend lumbar surgery if there is severe persistent, debilitating lower extremity complaints, clear clinical and imaging evidence of a specific lesion corresponding to a nerve root or spinal cord level level, corroborated by electrophysiological studies which is known to respond to surgical repair both in the near and long term documentation does not provide this evidence. The California MTUS guidelines do recommend spinal fusion if there is evidence of fracture, dislocation or instability. Documentation does not give any evidence of this magnetic resonance imaging scan (MRI) showed no severe canal or foraminal stenosis or nerve root impingement. His provider recommended an anterior interbody lumbar arthrodesis with cages and graft to treat his lumbosacral spondylosis without myelopathy and lumbago. Documentation does not present evidence of instability or radiculopathy. According to the Guidelines for the performance of fusion procedures for degenerative diseases of the lumbar spine, published by the joint section of the American Association of Neurological surgeons and Congress of Neurological surgeons in 2005 there was no convincing medical evidence to support the routine use of lumbar fusion at the time of primary lumbar disc excision. This recommendation was not changed in the update of 2014. The update did note that fusion might be an option if there is evidence of spinal instability, chronic low back pain and severe degenerative changes. Documentation does not show instability or severe degenerative changes. The documentation does not support California MTUS criteria that the requested procedure is medically reasonable and necessary. The requested treatment: Anterior/posterior spinal fusion at L5-S1 with right L5-S1 laminotomy with neuromonitoring during surgery is not medically necessary and appropriate.

Pre-operative labs: CBC: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-operative labs: PTT and INR: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-operative labs: metabolic panel: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-operative labs: UA: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-operative 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-operative 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-operative surgical 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-operative physical therapy x12 sessions, twice weekly for 6 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.