

Case Number:	CM15-0048109		
Date Assigned:	04/14/2015	Date of Injury:	10/25/2005
Decision Date:	05/07/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	03/13/2015

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 48 year old male, who sustained an industrial injury on 10/25/2005. He has reported subsequent back pain and was diagnosed with lumbar spondylosis with facet arthropathy at L4-L5 and L5-S1. Treatment to date has included oral pain medication, medial branch blocks and surgery. In a progress note dated 02/17/2015, the injured worker complained of worsening pain with back extension, pain down into the bilateral posterior thighs and lower extremity weakness. Objective findings were notable for limited back extension secondary to increased pain. The physician requested a L4-L5 and L5-S1 posterior spinal fusion and associated surgical services including posterior segmental instrumentation, intraoperative neurophysiology testing, needle electromyography, hospital stay quantity of 3, primary care physician and cardiac clearance, standard pre-operative labs, chest x-ray, electrocardiogram and Aspen LSO brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 posterior spinal fusion QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305 and 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 California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation of 2/17/2015 shows this patient has been complaining of pain in the back. Documentation does not disclose disabling lower extremity symptoms. The guidelines also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The note of 2/17/2015 showed no motor weakness in the legs and the patient could forward flex and almost reach the ground. The requested treatment is for lumbar spinal fusions. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: L4-5 posterior spinal fusion QTY: 1.00 is/are not medically necessary and appropriate.

L5-S1 posterior spinal fusion QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305 and 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 California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation of 2/17/2015 shows this patient has been complaining of pain in the back. Documentation does not disclose disabling lower extremity symptoms. The guidelines also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The note of 2/17/2015 showed no motor weakness in the legs and the patient could forward flex and almost reach the ground. The requested treatment is for lumbar spinal fusions. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: L5-S1 posterior spinal fusion QTY: 1.00 is/are not medically necessary and appropriate.

Associated surgical service: Posterior segmental instrumentation , L4-5 and L5-S1: 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: Intraoperative neurophysiology testing Qty: 1.00: 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: Needle electromyography: 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: Hospital stay Qty: 3.00: 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: PCP and cardiac clearance Qty: 1.00: 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 requested treatment: L5-S1 posterior spinal fusion QTY: 1.00 is not medically necessary and appropriate, then the requested treatment: Associated surgical service: PCP and cardiac clearance QTY: 1.00 is not medically necessary and appropriate.

Associated surgical service: Standard pre op labs Qty: 1.00: 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: Chest X- ray Qty: 1.00: 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: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical service: Aspen LSO Brace Qty: 1.00: 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.