

Case Number:	CM15-0063519		
Date Assigned:	04/20/2015	Date of Injury:	04/30/1997
Decision Date:	05/18/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	04/03/2015

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 47 year old male patient who sustained an industrial injury on 04/30/97. The patient underwent fluoroscopy guided epidural pharmacological cocktail placement on 06/17/2014. Prior diagnostic testing to include: radiography study, magnetic resonance imaging, an emergency room visit dated 03/12/2015 reported the chief complaint of low back pain. The patient reports having had fallen two weeks prior and hurt his low back. He stated hearing a "popping" noise when he fell. He states that he also hurt his shoulder when he fell. Current medications are: Hydrocodone, and unknown muscle relaxant. He was diagnosed with low back pain, lumbar radiculopathy and right shoulder strain. The plan of care involved: following up with spine specialist, use Percocet for pain, Valium for spasm, along with a short course of prednisone. A follow up visit dated 10/07/2014 reported the patient having had a cortisone injection on 07/01/2014. He has a prior history of shoulder surgery. Of note, he did get prescription for physical therapy and has not gone as of yet. The patient's prior surgical history consists of left rotator cuff repair, left arthroscopic shoulder repair, right arthroscopic knee repair, lumbar spinal fusion, lumbar spinal decompression, and low back disc surgery. Current medications show Norco 5/325mg, Flexeril. The impression noted left shoulder impingement syndrome and small rotator cuff tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior L2-L3 Decompression and Fusion with Instrumentation, Use of Allograft and/or Autograft: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition, web, 2013, Low Back Chapter, Fusion (Spinal).

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

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 provider attests there is instability. The radiologist's report of 3/12/15 does not support that opinion. The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation 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 requested treatment is for a posterior lumbar decompression and fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: Posterior L2-L3 Decompression and Fusion with Instrumentation, Use of Allograft and/or Autograft is NOT Medically necessary and appropriate.

Pre-Operative 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical service: Inpatient 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.

Pre-Operative PT/PTT: 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-Operative BMP: 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-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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-Operative Urinalysis: 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: Assistant Surgeon: 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.