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| Case Number: | CM15-0068710 | | |
| Date Assigned: | 04/16/2015 | Date of Injury: | 03/28/2013 |
| Decision Date: | 05/15/2015 | UR Denial Date: | 03/23/2015 |
| Priority: | Standard | Application Received: | 04/10/2015 |

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 40 year old male patient who sustained an industrial injury on 03/28/2013. A follow up visit dated 02/20/2015 reported subjective complaints of having intractable back pain. The following diagnoses are applied: disc protrusion L4-5, left sided intraforaminal area; chondral nerve root mild to moderate left foraminal narrowing and mild right foraminal narrowing; disc protrusion L5-S1; left sided sacroilitis; left lower extremity radiculopathy; acute aggravation with acute change in symptoms, and conjoint nerve root. The plan of care involved: candidate for surgical intervention. A secondary treating office visit dated 10/02/2014 reported subjective complaint of abdominal pain, improving acid reflux, constipation and worsening diarrhea. The following diagnoses are applied: abdominal pain, acid reflux, constipation, diarrhea, hypertension and shortness of breath. The plan of care involved urine toxicology, pending ultra sound, echo results. Recommending the patient undergo cardiorespiratory work up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior lumbar interbody fusion L5-S1 with instrumentation and plate: 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); Official Disability Guidelines Low Back Chapter, AMA Guides (Radiculopathy, Instability), Decompression.

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 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 an anterior lumbar interbody fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: Anterior lumbar interbody fusion L5-S1 with instrumentation and plate is not medically necessary and appropriate.

Associated surgical service: Post-op 3 day in-patient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Hospital length of stay (LOS) Guidelines.

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: Pre-operative clearance to include consultation, labs, EKG, and Chest X-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back -Lumbar & Thoracic (Acute & Chronic).

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 for lumbar spine surgery: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); (Low Back Chapter) Surgical Assistant.

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: Vascular surgeon for lumbar spine surgery: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); (Low Back Chapter), (<http://www.aaos.org/about/papers/positions/1120.asp>).

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: Post-op Lumbar back brace; bone growth stimulator for lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back Chapter.

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.