

Case Number:	CM15-0078951		
Date Assigned:	04/30/2015	Date of Injury:	10/02/1999
Decision Date:	05/29/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/24/2015

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 70 year old male patient who sustained an industrial injury on 10/02/1999. A recent primary treating office visit dated 03/24/2015 reported the patient being status post decompressive laminectomies on 11/24/2014. He reported immediate improvement in pain, but is with continued lower back pain, worse on the left side. The pain radiates to the bilateral upper buttocks. He continues to use Norco 10/325mg, and Naprosyn. The patient had undergone both radiographic study and magnetic resonance imaging. The impression noted: severe multi-level degenerative disc disease; status post laminectomies; grade I degenerative spondylolisthesis with moderate left foraminal stenosis; severe left foraminal stenosis; and broad based disc bulging with moderate lateral recess and moderate bilateral foraminal stenosis. The plan of care involved: recommendation for additional surgical intervention, continue with current medications, and follow up. A primary treating follow up visit dated 12/09/2014 reported subjective complaint of having "some intermittent aching in his lower back, mostly with movement." He takes Norco 10/325mg and states wishing to restart Naprosyn again. He is diagnosed with status post decompression for spinal stenosis as well as lumbar spondylolisthesis. The plan of care involved: encouraging walking for exercise; prescribed Norco, and Naprosyn, recommending physical therapy sessions, repeat radiography study and follow up in 4-5 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-S1 posterior decompression and fusion with instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation shows patient complaining primarily of low back pain. Documentation does not show a program of home exercises or a program of conservative therapy. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: L3-S1 posterior decompression and fusion with instrumentation is NOT Medically necessary and appropriate.

Associated surgical services: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical services: Labs: CBC with diff, CMP, UA, PT/PTT, INR, 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 services: 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.

Associated surgical services: 3 day 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.