

Case Number:	CM15-0092453		
Date Assigned:	05/20/2015	Date of Injury:	07/07/2014
Decision Date:	06/18/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/13/2015

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 37 year old male who sustained an industrial lifting injury to his lower back on 07/07/2014. The injured worker was diagnosed with thoracic/lumbosacral neuritis or radiculitis, lumbar spinal stenosis with neurogenic claudication and lumbago. Treatment to date includes diagnostic testing with lumbar spine magnetic resonance imaging (MRI) on September 30, 2014 demonstrating degenerative disc disease of the lumbar spine, most prominent at L5-S1 and moderate disc height loss at L5-S1 with a 4-5mm broad based disc bulge, mild facet arthropathy without significant central canal narrowing and mild foraminal narrowing bilaterally; a lumbar Computed Tomography (CT) on October 28, 2014 demonstrating no central canal or foraminal stenosis with L5-S1 degeneration, and a 5 mm broad based right paracentral disc bulge with encroachment traversing the right S1 nerve root and multiple lumbosacral x-rays on October 27, 2014 noting retrolisthesis of L5-S1 with no defect. The injured worker received conservative measures, physical therapy, transforaminal epidural steroid injection bilateral L5-S1 on November 17, 2014, spine consultation and medications. According to the primary treating physician's progress report on April 9, 2015 and April 27, 2015, the injured worker has continued pain which was unchanged from previous visits. On March 25, 2015 the injured worker was evaluated by an orthopedic consultation. According to this report the injured worker continues to experience back pain radiating to his legs and groin with numbness and tingling into his legs. Physical examination noted a non-antalgic, non-spastic gait pattern with tenderness to palpation at the L5-S1 segment and increasing pain with extension past neural. Range of motion is overall restricted in all planes without major motor or sensory deficits distally and negative

straight leg raise bilaterally. Current medications are listed as Ultram and Ibuprofen. Treatment plan consists of medications, add Tylenol as necessary and awaiting the current request for a L5-S1 Posterior Decompression, Fusion, & Instrumentation, Pre-Operative Medical Clearance, Associated surgical service: Assistant Surgeon, intra-operative monitoring, in patient 2 day stay, back brace, cold therapy unit and post-operative physical therapy, 12 visits

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 Posterior Decompression, Fusion, & Instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

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 cervical 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 does not provide this evidence. 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: L5-S1 Posterior Decompression, Fusion, & Instrumentation is not medically necessary and appropriate

Pre-Operative 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 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.

Associated surgical service: Back Brace: 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.

Post-Operative Physical Therapy, 12 visits: 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: In-Patient Stay (2 days): 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 Monitoring: 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: Cold Therapy Unit: 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.