

Case Number:	CM15-0092517		
Date Assigned:	05/19/2015	Date of Injury:	06/07/2013
Decision Date:	06/18/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	05/14/2015

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 29-year-old male, who sustained an industrial injury on 6/07/2013. He reported back pain from repetitive lifting. The injured worker was diagnosed as having lumbar spine 5mm protrusion at left L5-S1, lumbar spine congenital fusion at L4-5, hypoplastic right L5-S1 facet joint, and left L5-S1 disc protrusion, lumbar spine narrowing of disc space with 2.5mm posterior osteophyte disc complex, lumbar spine radiculitis, and lumbar spine spondylosis at L4-5 and L5-S1. Treatment to date has included diagnostics, physical therapy, transforaminal epidural steroid injection 4/2014, medial branch block 11/2014 and 2/2015, facet joint injection 2/2015, and medications. Currently (4/16/2015), the injured worker complains of constant low back pain with radiation to his bilateral hips. He also described pain in his upper back and tailbone area. He had limited and painful movement of his back. Current medications for pain included Dilaudid, Exalgo, and Robaxin. Exam of the lumbar spine noted tenderness to palpation over the midline at T11-L2 and tenderness over the L4-S1 region and bilateral paraspinals, left greater than right. He ambulated with an antalgic and guarded gait secondary to pain. Neurosurgical progress report was reviewed with recommendation for L4-5 and L5-S1 interbody grafting and internal fixation, with pre-operative evaluation including x-rays of the lumbar spine, and magnetic resonance imaging of the thoracic spine. Acupuncture was also recommended to the lumbar spine (6-sessions) to decrease pain and inflammation, increase flexibility and endurance, and help with activities of daily living. His work status was total temporary disability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interbody Grafting and Internal Fixation L4-L5 and L5-S1: 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 fusion (spinal).

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. The guidelines note the patient would have failed a trial of conservative therapy. Documentation does not show this evidence. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. Therefore, the requested treatment is not medically necessary and appropriate.

Pre-Operative Evaluation: 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.

X-Ray of the Lumbar Spine: 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.

Acupuncture for the Lumbar Spine (6-sessions, once a week for 6 weeks): 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.