

Case Number:	CM15-0094379		
Date Assigned:	05/20/2015	Date of Injury:	01/27/2003
Decision Date:	06/22/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/15/2015

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 52-year-old male who sustained an industrial injury on 01/27/2003. The initial complaints of injury and diagnoses were not mentioned in the clinical notes. Treatment provided to date has included: physical therapy (12 weeks); lumbar injections (2); chiropractic treatments; and medications (Ultram and Zanaflex). Diagnostic tests performed include: x-rays of the lumbar spine (03/06/2015) showing spondylosis at L4-5 and L5-S1 with grade 1 retrolisthesis; MRI of the lumbar spine (03/06/2015) showing severe bilateral foraminal stenosis at L3-4, L4-5 and L5-S1, severe spondylosis at L4-5 and L5-S1, preserved disc height at L3-4, and posterior annular fissure; and electrodiagnostic testing (03/13/2015) with normal findings. There were no noted previous injuries or dates of injury, and no noted comorbidities. On 04/08/2015, physician progress report noted lumbar pain and left lower extremity pain from the knee down. There was no pain severity rating or description of pain provided. Additional complaints include diminished sensation in the left quad. The physical exam revealed normal inspection of the lumbar spine, normal physiologic lordosis, normal range of motion in the lumbar spine, decreased strength in the left quad, tibialis anterior, gastrocnemius, extensor hallucis longus and peroneal, normal skin exam, decreased reflexes bilaterally, and decreased sensation in the left calf, dorsal and plantar foot. The provider noted diagnoses of thoracic/lumbosacral neuritis, lumbar spinal stenosis with neurogenic claudication, and spondylosis. Due to increasing lumbar pain, radicular pain to the left lower extremity, left foot drop, intermittent incontinence and evolving cauda equine syndrome the injured worker agrees to the plan for surgical intervention. Plan of care includes L4-5 and L5-S1 anterior discectomy and

fusion with possible L3-4 discectomy and fusion, posterior L3-S1 instrumented fusion, co-surgeon, 3 day inpatient stay, and associated surgical services consisting of post-operative lumbar brace purchase, post-operative front wheel walker, post-operative 3-in-1 commode purchase and bone growth stimulator purchase. Requested treatments include: L4-5 and L5-S1 anterior discectomy and fusion with possible L3-4 discectomy and fusion, posterior L3-S1 instrumented fusion, co-surgeon, 3-day inpatient stay, and associated surgical services consisting of post-operative lumbar brace purchase, post-operative front wheel walker, post-operative 3-in- 1 commode purchase and bone growth stimulator purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5, L5-S1 Anterior Discectomy and Fusion, Possible L3-4 Discectomy and Fusion, Posterior L3-S1 Instrumented Fusion: 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 (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 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 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 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 requested treatment is not medically necessary and appropriate.

Co-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.

Inpatient Length of Stay (3-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.

Post-Operative Lumbar Brace (purchase): 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 Front Wheeled Walker: 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 3-in-1 Commode (purchase): 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 Bone Growth Stimulator (purchase): 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.