

Case Number:	CM15-0097338		
Date Assigned:	05/28/2015	Date of Injury:	08/20/2013
Decision Date:	07/01/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	05/20/2015

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 30-year-old male, who sustained an industrial injury on August 20, 2013 while working as a construction worker. The injured worker sustained a low back injury related to constant lifting. The injured worker was noted to have had prior work related injuries. The prior injuries included a left hand injury which required surgery and a right wrist and hand injury related to a motor vehicle accident. The diagnoses have included lumbar myofascial sprain/ strain, lumbar spondylosis without myelopathy and bilateral pars fracture at lumbar five. Treatment to date has included medications, radiological studies, epidural steroid injections and physical therapy. Current documentation dated May 11, 2015 notes that the injured worker reported persistent low back pain radiating into the bilateral lower extremities. Examination of the lumbar spine revealed bilateral paraspinous and midline tenderness. Range of motion was decreased. The treating physician's plan of care included requests for a posterior lumbar laminectomy fusion and instrumentation at lumbar five-sacral one, anterior lumbar interbody fusion at lumbar five-sacral one, assistant surgeon, hospital stay of three days, bone growth stimulator, 3-in-1 commode, front wheel walker, lumbar-sacral orthosis back brace, post-operative home health nurse (dressing change and check for 14 days) and the post-operative medications Norco 10/325 mg #m 60, Soma 350 mg # 30, and Keflex 500 mg # 90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior Lumbar Laminectomy Fusion and Instrumentation at 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, Hardware.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-7.

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. Documentation does not include x-rays demonstrating pathologic motion. 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 does not contain 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: Posterior Lumbar Laminectomy Fusion and Instrumentation at L5-S1 is NOT medically necessary and appropriate.

Hospital 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.

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.

Anterior Lumbar Interbody Fusion at 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.

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. Documentation does not include x-rays demonstrating pathologic motion. 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 does not contain 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: Anterior lumbar interbody fusion at L5-S1 is NOT medically necessary and appropriate.

Associated Surgical Service: Bone Growth Stimulator: 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: 3-in-1 Commode: 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: Front Wheel 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.

Associated Surgical Service: LSO 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 Home Health Nurse (dressing change and would check for 14-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 Norco 10/325mg, #60: 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 Soma 350mg, #30: 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 Keflex 500mg, TID, #90: 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.