

Case Number:	CM15-0099394		
Date Assigned:	06/01/2015	Date of Injury:	08/27/2013
Decision Date:	07/07/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	05/22/2015

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 45 year old male, who sustained an industrial injury on August 27, 2013, incurring lower back injuries. He was diagnosed with lumbar degenerative disc disease and radiculitis. Treatment included epidural steroid injection, ice and pain medications. Magnetic Resonance Imaging of the lumbar spine revealed lumbosacral disc protrusions. Currently, the injured worker complained of recurrent, constant low back pain, 7 out of 10 on a pain scale from 1 to 10, radiating into the left buttocks, thigh, hip and leg aggravate by prolonged periods of time standing. The treatment plan that was requested for authorization included lumbar fusion, a three day inpatient hospital stay, surgical assistant, lumbar brace and bone growth stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 Transforaminal Lumbar Interbody Fusion, cage/screws, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar Spinal Fusion.

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 requested treatment: L4-S1 Transforaminal Lumbar Interbody Fusion, cage/screws, QTY: 1 is NOT Medically necessary and appropriate.

Associated surgical service: Inpatient Hospital Stay (days), QTY: 3: 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: Surgical Assistant: 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: Lumbar Brace, QTY: 1: 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: External Bone Growth Stimulator, QTY: 1: 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.