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| Case Number: | CM14-0007920 | | |
| Date Assigned: | 02/12/2014 | Date of Injury: | 09/09/2009 |
| Decision Date: | 08/14/2014 | UR Denial Date: | 12/20/2013 |
| Priority: | Standard | Application Received: | 01/21/2014 |

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California, New York, New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 40-year-old male with a 9/9/09 date of injury, when he was picking strawberries and felt severe pain in the back with numbness and pain in the legs, right worse than left. Imaging from 10/22/11 revealed mild L4-5, L5-S1 degenerative. Electrodiagnostics from 1/2011 were unremarkable. Discogram confirmed pain at L4-5 and L5-S1. 3/27/13 CT of the lumbar spine revealed at L4-5 mild right and moderate left neural foraminal narrowing. At L5-S1, there was focal disc protrusion directed towards the left lateral recess and left neural foraminal zones, superimposed on a 2 mm symmetric disc bulge; mild moderate right and moderate left neural foraminal narrowing. 12/5/13 Progress note described difficulties with ADLs and no improvement from conservative treatment. 1/22/14 letter of appeal described radiation of low back pain into the buttocks; psychological clearance by [REDACTED], failure of numerous conservative treatment, including PT and ESI. In addition, discogram was noted to have control at L3-4, and positive at L4-5 and L5-S1. 2/3/14 psychological progress note documented several factors that might negatively influence spine surgery. Additional CBT was recommended. Treatment to date has included PT, activity modification, lumbar ESIX2, and medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 POSTERIOR SPINAL FUSION WITH L4-L5, L5-S1 INTERBODY FUSION:

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, BACK CHAPTER, PAGE 20.

MAXIMUS 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.

Decision rationale: Medical necessity for the requested fusion at L4-5 and L5-S1 is not established. This request previously obtained an adverse determination due to lack of instability on flex/ex films, as well as no psychological evaluation. In addition, discogram did not have an asymptomatic control level. The 1/22/14 letter of appeal addressed these issues, except for the lack of instability. CA MTUS states that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Without evidence of loss of motion segment integrity, greater than 4.5 mm in the lumbar spine, the surgical request is not substantiated. Records also indicate from May of 2013 that there was a diskography showing concordant pain at L4-5 and L5-S1. The MTUS guidelines do not support diskography as a pre-operative indication for fusion. Therefore the request is not medically necessary.

TWO DAY INPATIENT HOSPITAL STAY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter;

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

PRE-OPERATIVE LABS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

CHEST X-RAY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

ELECTROCARDIOGRAM (EKG): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.