

Case Number:	CM14-0171335		
Date Assigned:	10/23/2014	Date of Injury:	08/30/2012
Decision Date:	12/02/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	10/16/2014

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 Spine Surgeon and is licensed to practice in Texas. 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 injured worker is a 55-year-old male who reported an injury on 08/30/2012. The mechanism of injury was not submitted for clinical review. The diagnoses include L4-5 pseudoarthrosis, status post L4-5 decompression on 03/12/2013, status post anterior lumbar interbody fusion at L4-5 in 04/2013, an L3-4 disc herniation with radiculopathy, and urinary retention. Previous treatments included medication, physical therapy, and epidural steroid injections. Surgical history included a lumbar fusion at L4-5 in 04/2013 and an L4-5 decompression on 03/12/2013. Per the clinical note dated 09/24/2014, it was reported the injured worker complained of excruciating back pain with radiation into the bilateral legs, left initially worse than right, but now equally impaired. He describes the pain as stabbing like sensation in the right leg which impairs his day to day functions. Upon the physical examination, the provider noted the lumbar spine demonstrated a well healed incision in the abdominal area the posterior lumbar spine. The provider noted the injured worker had severe difficulty with rising from a seated to standing position. The lower extremity sensation was noted to be normal on the left and right of L1 and L2 nerve distributions. L3, L4, and L5 nerve distributions have decreased sensation. The provider noted the injured worker to have trigger points or discrete focal hyperirritable spots along a taut band of skeletal muscle which caused referred pain with palpation. The provider requested an L3-5 revision decompression and possible fusion if instability is demonstrated intraoperatively. The Request for Authorization was submitted and dated 10/07/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior L3-L5 Revision Decompression and possible fusion.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion (spinal)

Decision rationale: The request for Posterior L3-L5 Revision Decompression and possible fusion is not medically necessary. The California MTUS/ACOEM Guidelines note spinal fusion in the absence of fracture, dislocation, complications of tumor, or infection is not recommended. Except for cases of trauma related spinal fracture or dislocation, fusion of the spine is not usually considered during the first 3 months of symptoms. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back pain problems, in absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. The guidelines note that, although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. Surgical considerations within the first 3 months of onset of acute back symptoms are only considered when serious spinal pathology of nerve root dysfunction are not responsive to conservative treatment. Indications include clear clinical signs, imaging, and electrophysiological evidence of a lesion that has been shown to be beneficial in both short and long term for surgical repair. The guidelines recommend the failure of conservative therapy. The clinical documentation submitted indicated the injured worker has tried and failed conservative therapy and with prior epidural steroid injections. The provider noted the injured worker to have decreased sensation of the L3, L4, and L5 nerve distributions. However, the clinical documentation submitted failed to indicate an imaging study to corroborate the diagnoses warranting the medical necessity for the request. Therefore, the request is not medically necessary.

Associated surgical service: 2 days inpatient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment for Workers Compensation, Low Back Chapter, Hospital Length of Stay

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: Pre Operative medical clearance.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for clinical systems improvement (ICSI) Pre Operative Evaluation. 2008 Jul. 32p.

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: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

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: OrthoFix Bone Growth Stimulator.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Bone Growth Stimulator.

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.