

Case Number:	CM14-0027585		
Date Assigned:	06/13/2014	Date of Injury:	01/12/2006
Decision Date:	07/16/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	03/04/2014

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 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 58 year old female who had a work related injury on 01/12/06, mechanism of injury was noted as a lifting injury. She was diagnosed with lumbosacral spondylosis. She complained of lower back pain that radiated to the bilateral legs, left greater than right. She underwent an L4-5 lumbar decompression with interbody instrumentation and fusion in 2006 and in 2011 she underwent an L3-4 lateral transpoas interbody fusion with posterior instrumentation and decompression. The most recent progress note dated 02/06/14 noted that the injured worker continued to complain of chronic low back pain and left leg pain. The physical examination noted normal gait the reflexes were 2+ and symmetrical and the patient had normal lumbar lordosis without scoliosis. There was no tenderness to palpation, no spasm noted and diminished sensation along the left lateral leg which is chronic. The patient's range of motion consisted of Flexion 50 degrees, lumbar extension 20 degrees, right rotation 45 degrees, left rotation 45 degrees, right lateral flexion 20 degrees, left lateral flexion 20 degrees. Strength is rated 5/5 in lower extremities. Negative straight leg raise, clonus, foot drop, or Babinski's reflex. An MRI of the lumbar spine dated 12/27/13 at L2-3 there is mild broad based disc bulge, slightly worse than compared prior study, which minimally effaces the anterior thecal sac. The conclusion was overall relatively stable exam including status post surgical changes consistent with anterior spinal fusion at L3 through L5 including intervertebral prosthetic spacer at L3-4.

IMR ISSUES, DECISIONS AND RATIONALES

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

INSET SPINE FIXATION DEVICE, INPATIENT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307.

Decision rationale: The clinical documentation submitted for review does not support the request for the Inset spine fixation device. The records provide no documentation of the level the device is intended for. Further, the type of device is not specified, suggesting that some form of fusion will be required. Therefore medical necessity has not been established.