

Case Number:	CM14-0077237		
Date Assigned:	07/18/2014	Date of Injury:	03/28/2011
Decision Date:	08/25/2014	UR Denial Date:	04/24/2014
Priority:	Standard	Application Received:	05/27/2014

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, has a subspecialty in Spinal Surgery and is licensed to practice in California. 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 claimant is a 40 year old with reported industrial injury on 3/28/11. Exam note from 4/2/14 demonstrates complaint of low back pain with radiation into the buttocks right greater than left. The exam demonstrates restricted lumbar range of motion with negative straight leg raise testing. The motor examination demonstrates 4/5 weakness in the right EHL. MRI from 6/18/13 demonstrates prior right lumbar laminectomy at L4/5 and L5/S1 with epidural enhancement. Normal alignment of the lumbar vertebrae is noted without spondylolisthesis at L3-S1. Moderate bilateral foraminal narrowing is noted at L4/5. No evidence of stenosis is noted in the central canal, lateral recesses or foramina at L5/S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 anterior fusion, L4-S1 posterior fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 ACOEM Guidelines Chapter 12 Low Back Complaints page 307 states that lumbar fusion, except for cases of trauma-related spinal fracture or dislocation, is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. According to the Official Disability Guidelines, Low back, Fusion (spinal) should be considered for 6 months of symptoms. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, Official Disability Guidelines states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-operative, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm or severe stenosis on MRI from 6/18/13 to warrant a two level fusion. Therefore, the request is not medically necessary.

Co-surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Co-Surgeon, Assistant Surgeon, and Assistant at Surgery guidelines.

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 assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Co-Surgeon, Assistant Surgeon, and Assistant at Surgery guidelines.

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.

Posterior intraoperative neuromonitoring: 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: As the requested surgical procedure is not medically necessary, the determination is for non-certification for posterior intraoperative monitoring.

