

Case Number:	CM14-0084480		
Date Assigned:	06/11/2014	Date of Injury:	05/04/2010
Decision Date:	07/15/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/04/2014

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 47 year old female who reported an injury to her low back. The clinical note dated 11/22/13 indicated the injured worker complaining of persistent back pain and leg pain. The injured worker previously underwent functional restoration program. However, the injured worker continued with complaints of low back pain. The injured worker stated the pain was moderate to severe but was exacerbated with prolonged standing and walking. Upon exam, tenderness was identified at the lumbar paraspinals along with spasms. The injured worker demonstrated 20 degrees of extension and 40 degrees of flexion in the lumbar spine. Clinical note dated 01/03/14 indicated the injured worker continuing with intense low back pain the injured worker had diminished complaints of pain. Sacroiliac joint tenderness was identified bilaterally. The clinical note dated 02/04/14 indicated the injured worker complaining of low back pain radiating to the mid back rated 9/10. X-rays revealed disc height loss at L4-5 and L5-S1 with neural foraminal narrowing. The clinical note dated 03/07/14 indicated the injured worker complaining of aching and burning type pain in the upper right back and low back. The injured worker ambulated with a hypolordosis and guarded gait. The MRI of the lumbar spine dated 04/15/14 revealed minimal annular bulge at L4-5. No stenosis or central canal or neural foraminal narrowing was identified. Lateral disc protrusion was identified at L5-S1. No significant stenosis was identified on the right. Central canal and left sided neural foraminal narrowing central canal and left neural foramen remained patent. The clinical note dated 04/18/14 indicated the injured worker rating her low back pain 10/10. The injured worker failed a long course of non-surgical treatments. The Utilization Review dated 05/27/14 resulted in denial for lumbar fusion as no information was submitted confirming instability or completion of psychosocial screening.

IMR ISSUES, DECISIONS AND RATIONALES

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

ANTERIOR LUMBAR INTERBODY FUSION L4-L5 AND L5-S1 USING CAGES AND ALLOGRAFT. POSTLATERAL FUSION AT L4-L5 AND L5-S1 USING RIGID SEGMENTAL INTER FIXATION AND ALLOGRAFT.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-7.

Decision rationale: The clinical documentation indicates the injured worker complaining of ongoing low back pain despite involvement with therapeutic treatments. A lumbar fusion is indicated for injured workers who have completed all conservative treatments and psychosocial screening and x-rays confirming instability. The submitted x-rays revealed no significant instability at L4-5 or L5-S1. No information was submitted regarding completion of psychosocial screening addressing any confirmed issues and potential outcomes of the pending surgery. Given this, the request is not indicated as medically necessary.

ASSISTANT VASCULAR SURGEON: 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.