

Case Number:	CM14-0089428		
Date Assigned:	07/23/2014	Date of Injury:	07/16/2013
Decision Date:	08/29/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/13/2014

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 35-year-old male who reported an injury on 07/16/2013. The mechanism of injury was not stated. Current diagnoses include L5-S1 grade 1 anterior spondylolisthesis, left trochanteric bursitis, L3-4 early disc degeneration, C6-7 small disc protrusion, and rule out sacroiliac arthrosis. The injured worker was evaluated on 05/12/2014 with complaints of left-sided lower back pain with radiation into the lower extremities. Physical examination revealed a minimally antalgic gait, 5/5 motor strength, painful Patrick's testing on the left and positive straight leg raising on the left. Treatment recommendations at that time included a posterior decompression and fusion at L5-S1. It is noted that the injured worker underwent a CT scan of the lumbar spine on 04/29/2014, which indicated grade 1 anterolisthesis at L5-S1, annular bulging at L4-S1 and negative foraminal narrowing. The injured worker also underwent an MRI of the lumbar spine on 11/01/2013, which indicated no evidence of central spinal stenosis or neural foraminal stenosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior Decompression and Fusion L5 - S1 with Instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (spinal).

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patient who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, clear clinical, imaging and electrophysiologic evidence of a lesion and a failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include identification and treatment of all pain generators, completion of all physical medicine and manual therapy interventions, documented spinal instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels and completion of a psychosocial screening. As per the documentation submitted the injured worker's physical examination only revealed positive straight leg raising on the left with a minimally antalgic gait. There is no documentation of a significant musculoskeletal or neurological deficit. There is no mention of an exhaustion of conservative treatment. There is no evidence of spinal instability upon flexion and extension view radiographs. There is also no documentation of a psychosocial screening prior to the request for a lumbar fusion. Based on the clinical information received, the request is not medically necessary and appropriate.

Pre-Op Labs: 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 med necessary, none of the associated services are medically necessary.

Pre-Op Chest Xray: 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 med necessary, none of the associated services are medically necessary.

Pre-Op EKG: 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 med necessary, none of the associated services are medically necessary.