

Case Number:	CM14-0092385		
Date Assigned:	07/25/2014	Date of Injury:	12/15/1989
Decision Date:	08/28/2014	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	06/18/2014

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 male who reported an injury on 12/15/1989. The mechanism of injury was not stated. Current diagnoses included chronic pain syndrome, lumbar postlaminectomy syndrome, lumbar radiculopathy, sacroiliac joint dysfunction, myofascial pain syndrome, depression, anxiety, insomnia, status post arthrodesis in the lumbar spine, degenerative disc disease in the lumbar spine, and testicular pain. The injured worker was evaluated on 04/02/2014 with complaints of persistent lower back pain with radiation into the bilateral lower extremities. Physical examination revealed a slow and steady gait. Treatment recommendations at that time included a transforaminal epidural steroid injection, a back brace, and a bone stimulator. It is noted that the injured worker underwent an x-ray of the thoracolumbar spine on 03/18/2014, which indicated screw failure at the uppermost level of T11 with motion at the screw fracture line with flexion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior fusion Thoracic 11-5, with instrumentation, removal of hardware Thoracic 11 with 3 day inpatient stay.: Upheld

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

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) and Hardware implant removal.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients 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 CT myelogram or x-ray, spine pathology that is limited to 2 levels, and a psychosocial screening. As per the documentation submitted, there is no evidence of a significant musculoskeletal or neurological deficit upon physical examination. There is no documentation of a psychosocial screening prior to the request for a fusion. Based on the clinical information received and the above mentioned guidelines, the request is non-certified.

Pre-operative History & Physical (H&P), labs and electrocardiogram (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 medically necessary, none of the associated services are medically necessary.

Pre-operative Cardiac Consultation: 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.

DME purchase bone growth stimulator: 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.

