

Case Number:	CM14-0093803		
Date Assigned:	07/25/2014	Date of Injury:	10/10/2008
Decision Date:	08/28/2014	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	06/20/2014

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 63-year-old male who reported an injury on 10/10/2008. The mechanism of injury was not specifically stated. Current diagnoses include painful lumbar disc at L2-3, L2-3 stenosis, arthrodesis at L3 through S1, status post right knee arthroplasty, and status post left knee arthroplasty. The current medication regimen includes Norco 10/325 mg and ibuprofen 600 mg. It is also noted that the injured worker underwent an anterior interbody fusion. The injured worker was evaluated on 05/01/2014 with complaints of lower back and lower extremity pain. Physical examination revealed tenderness to palpation over the hardware in the lumbar spine, limited and painful range of motion of the lumbar spine, decreased sensation in the left lower extremity, positive straight-leg raising on the left, and normal motor strength in the bilateral lower extremities. Treatment recommendations at that time included a lumbar interbody fusion with removal of hardware. It is noted that the injured worker underwent an MRI of the lumbar spine on 02/28/2014, which indicated lateral recess narrowing at L4-5 and a loss of normal disc height at L2-3 with bilateral recess stenosis and moderate foraminal encroachment. The injured worker also underwent lumbar spine x-rays on 02/10/2014 which indicated severe degenerative disc disease at L2-3 with no acute compression fracture.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Lumbar Interbody Fusion through lateral approach L2-L3, Posterior Lateral Fusion with instrumentation, Removal of Posteroir hardware L3-L4, Application of intervertebral biomechanical device, Posterior segmental instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation ODG -Lumbar Spinal Fusion Low Back (XLIF) extreme Lateral Interbody Fusionweb 19th edition Low Back Section.

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 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. Official Disability Guidelines state preoperative clinical surgical indications for spinal fusion should include the 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. There is no documentation of spinal instability upon flexion and extension view radiographs. There is also no evidence of an exhaustion of conservative treatment prior to the request for an additional lumbar procedure. There is also no mention of the completion of a psychosocial screening prior to the request for a lumbar fusion. Based on the clinical information received and the above mentioned guidelines, the request is not medically necessary.

Inpatient hospital stay: 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.