

<b>Case Number:</b>	CM14-0096955		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	07/27/1984
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2014

### 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 76-year-old male who reported an injury on 07/27/1984. The mechanism of injury was not stated. The current diagnosis is failed back syndrome with pseudoarthrosis. The injured worker was evaluated on 04/03/2014 with complaints of lower back pain. It is noted that the injured worker has undergone multiple neurosurgical interventions consisting of a spinal fusion and revision with subtotal hardware removal. Previous conservative treatment includes pain management, epidural injection and medication. Physical examination revealed no acute distress, 5/5 motor strength, intact sensation, negative straight leg raising and tenderness to palpation. Treatment recommendations included a thoracic to pelvis posterior revision fusion. It is noted that the injured worker underwent a CT scan of the thoracic spine on 05/30/2014 which indicated severe discogenic degenerative changes at T9-10 with disc bulging and moderate left neural foraminal stenosis at T4-5.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Posterior Spinal Fusion T4 to Pelvis and Decompression w/Autograft:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 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 failure of conservative treatment. 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 instability upon CT scan or x-ray and a psychosocial screening. As per the documentation submitted, the injured worker has been previously treated with conservative care. However, there is no documentation of spinal instability upon flexion and extension view radiographs. There is also no documentation of a psychosocial screening prior to the request for a spinal fusion. Based on the clinical information received and the above mentioned guidelines, the request is not medically necessary.

**3-5 Day Inpatient 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.