MAXIMUS Federal Services

Case Number:	CM14-0209546		
Date Assigned:	12/24/2014	Date of Injury:	03/26/2001
Decision Date:	03/04/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Texas
Certification(s)/Specialty: Orthopedic Surgery

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 69-year-old female who reported an injury on 03/26/2001. The mechanism of injury was the injured worker was building a display and bent over to pick up a case of Gatorade drink and felt a pop in the lower back and has had insistent pain. The injured worker was diagnosed with back pain. Previous treatments included physical therapy, epidural steroid injections, opioid medication, and activity modification. Diagnostic studies included a CT myelogram of the lumbar spine dated 09/30/2014 that revealed moderate focal spinal canal stenosis seen at L1-2 and osteopenia. The injured worker had x-rays of the lumbar spine dated 10/20/2014 that revealed severe degenerative disc disease within the thoracolumbar junction disc spaces, and previous posterior instrumented fusion of L2 and L3 and previous laminectomy and posterolateral bony fusion of L2-S1. The injured worker also had an x-ray scoliosis series on 10/20/2014 that revealed thoracolumbar dextroscoliosis centered at the T12-L1 with Cobb angle of 12 degrees and status post L2-5 bilateral laminectomies with posterior fusion of L2-3. Pertinent surgical history included a previous lumbar spine instrumentation x2 in 2005 and 2009. The injured worker was seen for an office visit on 12/08/2014 where it was noted the injured worker complained of back pain. The injured worker was last seen on 10/06/2014 with complaints of severe back pain and bilateral radiculopathy. It was noted the injured worker had failed conservative treatment over many years. The physical examination revealed generalized tenderness at the lumbar paraspinal musculature. Neurovascular sensation was intact to light touch, and deep tendon reflexes were 2/4. Lower extremity strength was 5/5. The treatment plan indicated that the injured worker understood and wished to proceed with surgery exploration of

the spinal fusion, removal of the prior fusion, lumbar laminectomy with partial facetectomy and foraminotomy at L1-2, posterior spinal instrumentation at T10-L2, and posterolateral fusion at T10-L2. The Request for Authorization form details were submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Exploration of Fusion Lumbar Spine L2-3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion (spinal)

Decision rationale: The Exploration of Fusion Lumbar Spine L2-3 is not medically necessary. The documentation submitted for review does not show evidence of significant lower extremity weakness, decreased deep tendon reflexes, or decreased sensation. As such, the Exploration of Fusion Lumbar Spine L2-3 is not medically necessary.

Removal of Hardware L2-L3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Hardware implant removal (fixation)

Decision rationale: The requested Removal of Hardware L2-L3 is not medically necessary. The documentation submitted does not show evidence of broken hardware or other causes of pain such as infection being ruled out. The imaging studies submitted did not show evidence of instability to the hardware. Medical necessity is not substantiated.

Posterior Spinal Instrumentation T10, T11, T12, L1, L2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion (spinal)

Decision rationale: The requested Posterior Spinal Instrumentation T10, T11, T12, L1, L2 is not medically necessary. The documentation submitted did not show evidence of instability to warrant the requested surgical procedure. The documentation submitted for review does not show evidence of significant lower extremity weakness, decreased deep tendon reflexes, or decreased sensation. Medical necessity is not substantiated.

Posterolateral Spinal Fusion T10-T11, T11-T12, L1-L2 with autograft, allograft and fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion (spinal)

Decision rationale: The recommended Posterolateral Spinal Fusion T10-T11, T11-T12, L1-L2 with autograft, allograft and fluoroscopy is not medically necessary. The documentation submitted did not show evidence of spinal instability to warrant the spinal fusion. The documentation submitted for review does not show evidence of significant lower extremity weakness, decreased deep tendon reflexes, or decreased sensation. Medical necessity is not substantiated.