

Case Number:	CM15-0029181		
Date Assigned:	02/23/2015	Date of Injury:	11/01/2002
Decision Date:	04/22/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	02/17/2015

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: Oregon, California
 Certification(s)/Specialty: Neurological 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 56-year-old male who reported an injury on 11/01/2002. The mechanism of injury was not specifically stated. The current diagnoses include chronic low back pain with right leg pain, significant multiple comorbidities, severe paresthesia in the right lower extremity and chronic pain. The injured worker presented on 01/16/2015 for a follow-up evaluation regarding chronic low back pain. It was noted that the injured worker was not interested in injections. The injured worker reported low back pain with radiating symptoms including numbness and weakness in the right lower extremity. The current medication regimen includes gabapentin and tramadol. Upon examination there was difficulty performing heel and toe walking on the right side, tenderness at the L5-S1 region, 45 degree flexion, 10 degrees extension, 25 degree lateral bending, positive straight leg raise on the right, 4+/5 motor weakness and diminished sensation in the bilateral feet. Recommendations at that time included a posterior spinal fusion and instrumentation from L3-S1. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Consultation with a Co-Surgeon: 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.

Associated Surgical Service: Co-Surgeon: 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.

Anterior and Posterior Lumbar Interbody Fusion with Open Reduction at the L3-S1 Level:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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: 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 limitations 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 the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. In this case, there was no mention of an exhaustion of conservative management. There was no documentation of spinal instability upon flexion and extension view radiographs. There was also no mention of the completion of a psychosocial screening prior to the request for a lumbar fusion. Given the above, the request is not medically appropriate.

Associated Surgical Service: Assistant Surgeon: 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.