

Case Number:	CM15-0032074		
Date Assigned:	02/25/2015	Date of Injury:	04/09/2010
Decision Date:	04/22/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	02/20/2015

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 64-year-old male who reported an injury on 04/09/2010. The mechanism of injury was not specifically stated. The current diagnoses include status post removal of lumbosacral peripheral stimulator on 12/18/2014, status post multiple lumbar surgeries, flat back deformity syndrome, status post lumbar stimulator placement in 2011, status post left hip surgery in 2003, status post right hip surgery on 05/13/2014 and status post colon resection with reverse colostomy in 2007. The injured worker presented on 02/04/2015 with complaints of progressive low back pain, as well as lower extremity pain. The injured worker reported severe muscle spasm and difficulty controlling his lower extremities. Upon examination, there was significant tenderness upon palpation with referred pain to the bilateral buttock and flank regions, significantly diminished range of motion, difficulty rising from a seated to standing position, diminished reflexes in the bilateral lower extremities and 4-/5 motor weakness in the bilateral lower extremities. There was diminished sensation in the bilateral lower extremities as well. Recommendations at that time included a posterior L1-2 decompression and fusion from T12 to approximately L2. 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:

Anterior/Posterior Decompression and Fusion T12-L2, L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): (s) 305-307, 208, 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines: Indications for Surgery.

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 any recent conservative management prior to the request for an additional procedure. There was no documentation of spinal instability upon flexion and extension view radiographs. There was also no documentation of a psychosocial screening completed prior to the request for a lumbar fusion. Therefore, the patient does not meet criteria for the requested procedure as outlined by the abovementioned Guidelines. Given the above, the request is not medically appropriate.

Associated Surgical Service: Vascular 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: Ortho Fix 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.