MAXIMUS Federal Services

Case Number:	CM15-0040519		
Date Assigned:	03/10/2015	Date of Injury:	10/05/2001
Decision Date:	04/17/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/03/2015

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: New York
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:

This 51 year old female reported a repetitive use industrial injury from lifting heavy bags of dog and cat food at [redacted] on 10/5/01. She was diagnosed as having lumbago, adjacent segment degenerative disc disease and cervicalgia. On 03/22/2007, she underwent an anterior and posterior lumbar fusion with pedicle screw instrumentation L3-S1. She had an incision and drainage of a complex lumbar wound performed on 4/6/2007. Local wound debridement and placement of a wound vacuum device was done on 4/18/07. She continued to have pain. A spinal cord stimulator was placed and complicated by lead migration, which led to removal of the unit secondary to ineffectiveness. She evidently had relief from trigger point injections. An intrathecal morphine pump was placed on 08/09/2012. This became infected, she developed spinal meningitis and the unit was explanted on 11/8/2012. She complained of right knee pain and a right total knee joint arthroplasty was performed on 10/24/2013. She had recurrent low back pain and lumbar epidural steroid injections were performed above her fusion in 2013. Treatment to date has included lumbar MRI, spinal cord stimulator, physical therapy, lumbar CT on 9/9/14. The PR2 of 03/05/14, indicated she was having extreme tenderness to palpation over the abdominal scar from her anterior lumbar fusion, severe limitation in lumbar spine range of motion with forward flexion of 30 degrees, extension in neutral only, and positive bilateral straight leg raising tests with generalized lower extremity weakness of 3-/5 on the left and 3+/5 on the right. She had decreased sensory sensation in a non-dermatomal patter worse on the left. Her left Achilles reflex was absent and the right 1+. She was taking Morphine ER 30 mg tid and Lyrica 50mg tid, Morphine IR 15mg qid prn moderate to severe breakthrough pain, Tizanidine

for muscle spasms, Ibuprofen and cimetidine as well as topical Lidoderm patches. Acupuncture was recommended to try to help her pain. On 06/18/14, she had a lumbar CT myelogram. The thecal sac and neural foramina were patent. On 09/09/2014, she had a CT scan and MRI scan of the lumbar spine, which showed her fusions and pedicle screw instrumentation, were intact. She had an annular bulge of the L2-3 disc with degenerative change. No disc material was noted in the lower lumbar and lumbosacral discs. She had narrowing of the lateral recesses and buckling of the ligamentum flavum. The PR2 dated 1/16/15, noted the injured worker reports back pain that radiates to the buttock and makes it difficult to ambulate. She has not had any significant relief with the spinal cord stimulator or intrathecal pain pump and had them removed. The treating physician noted a positive straight leg raise test on the left at 90 degrees. The PR2 of 2/25/15 noted she weighed 260 pounds and was 64 inches tall. A request for authorization for medical treatment for a L1-2, L2-3 direct lateral fusion/revision T10-S1 fusion instrumentation was made, and then revised to include a vertebral corpectomy Lumb/sacral; 1verteb corpect lumb/sacral; ea add, arthrodesis w/mini diskect as noted in the application for IMR. The injured worker is a 51 year old female, who sustained an industrial injury on 10/5/01. She reported pain in the back related to lifting a heavy object. The injured worker was diagnosed as having lumbago, adjacent segment degenerative disc disease and cervicalgia. Treatment to date has included lumbar MRI, spinal cord stimulator, physical therapy, lumbar CT on 9/9/14 and pain medications. As of the PR2 dated 1/16/15, the injured worker reports back pain that radiates to the buttock and makes it difficult to ambulate. She has not had any significant relief with the spinal cord stimulator or intrathecal pain pump and had them removed. The treating physician noted a positive straight leg raise test on the left at 90 degrees.

IMR ISSUES, DECISIONS AND RATIONALES

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

L1-2, L2-3 Direct lateral fusion/revision T10-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

Decision rationale: The California MTUS guidelines recommend spinal fusion for traumatic fracture, dislocation and instability. The patient has undergone MRI scans, CT scans which show her instrumentation, and fusions are intact. The documentation does not show any instability. She has not had spinal fractures or dislocation. The guidelines also note that the patient should have clear clinical, imaging and electrophysiologic evidence of a lesion, which is, know to respond to surgical repair in the short and long term to fulfill criteria for surgery. The documentation does not present this evidence. The requested treatment L1-2, L2-3 direct lateral fusion/revision T10-S1 is not medically necessary and appropriate.

Inpatient length of stay times 3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on Non-MTUS Citation Since the requested treatment L1-2,L2-3 direct lateral fusion/revision T10-S1 is not medically necessary and appropriate, then Requested Treatment: Inpatient length of stay times 3 is not medically necessary and appropriate.

Decision rationale: Since the requested treatment L1-2, L2-3 direct lateral fusion/revision T10-S1 is not medically necessary and appropriate, then Requested Treatment: Inpatient length of stay times 3 is not medically necessary and appropriate.

Spinal cord monitoring/history and physical for labs/clearance (CBC with DIFF, CMP, PT, PTT, UA, chest X-ray, EKG): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on Non-MTUS Citation Since the requested treatment L1-2,L2-3 direct lateral fusion/revision T10-S1 is not medically necessary and appropriate, then Requested Treatment: Spinal cord monitoring/history and physical for labs/clearance (CBC with DIFF, CMP, PT, PTT, UA, chest X-ray, EKG) is not medically necessary and appropriate.

Decision rationale: Since the requested treatment L1-2,L2-3 direct lateral fusion/revision T10-S1 is not medically necessary and appropriate, then Requested Treatment: Spinal cord monitoring/history and physical for labs/clearance (CBC with DIFF, CMP, PT, PTT, UA, chest X-ray, EKG) is not medically necessary and appropriate.

LSO brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on Non-MTUS Citation Since the requested treatment L1-2,L2-3 direct lateral fusion/revision T10-S1 is not medically necessary and appropriate, then Requested Treatment: LSO brace is not medically necessary and appropriate.

Decision rationale: Since the requested treatment L1-2, L2-3 direct lateral fusion/revision T10-S1 is not medically necessary and appropriate, then Requested Treatment: LSO brace is not medically necessary and appropriate.