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| Case Number: | CM15-0048123 | | |
| Date Assigned: | 03/20/2015 | Date of Injury: | 02/26/2014 |
| Decision Date: | 05/06/2015 | UR Denial Date: | 02/06/2015 |
| Priority: | Standard | Application Received: | 03/13/2015 |

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 58-year-old male who reported an injury on 02/26/2014. The mechanism of injury was not specifically stated. The current diagnosis is lumbar disc protrusion. The injured worker presented on 01/02/2015 with complaints of ongoing lower back pain with radiating symptoms into the bilateral lower extremities. Pain was worsened with prolonged sitting, lifting, carrying, and bending. Upon examination, there was notable leg length asymmetry of approximately 1 inch shorter on the left than the right, tenderness on the left side in the L4-5 and L5-S1 distribution, paraspinal muscle spasm at the thoracolumbar junction, tenderness along the left superior iliac crest, 30 degrees forward flexion, 15 degrees extension, 5/5 motor strength, 2+ deep tendon reflexes, and intact sensation. Recommendations included an anterior lumbar fusion at L4-5 with neurodiagnostic monitoring and a cell saver. A request for authorization form was then submitted on 01/13/2015. The official MRI of the lumbar spine completed on 04/24/2014 was also submitted for review and revealed evidence of a 4 mm to 5 mm disc bulge at L4-5, causing displacement of the posterior ligaments, narrowing of the spinal canal, compression of the thecal sac and impingement of the L5 nerve root bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior lumbar interbody fusion L4-L5 with neurodiagnostic monitoring and cell saver:
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, Fusion (Spinal).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305 and 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 documentation of spinal instability upon flexion and extension view radiographs. In addition, while it was noted that the injured worker had been previously treated with an epidural steroid injection without an improvement of symptoms, there was no documentation of a recent attempt at conservative management in the form of active rehabilitation or exercise. There is also no documentation of a psychosocial screening completed prior to the request for a lumbar fusion. Given the above, the request is not medically appropriate at this time.

Associated surgical service: Inpatient stay, three (3) days: 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, Fusion (Spinal).

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.

Vascular Surgeon: 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, Fusion (Spinal).

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.

Assistant surgeon: 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, Fusion (Spinal).

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: LSO lumbosacral orthosis: 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, Fusion (Spinal).

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: Bone growth stimulator: 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, Fusion (Spinal).

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.

Pre-operative clearance to include consultation, Labs (CMP, CBC, PT, PTT, UA), EKG and chest X-ray: 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, Fusion (Spinal).

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.