

Case Number:	CM15-0050667		
Date Assigned:	03/24/2015	Date of Injury:	10/05/2001
Decision Date:	05/01/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	03/17/2015

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: 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:

The injured worker (IW) is a 50-year-old female who sustained an industrial injury on 10/05/2001. She reported low back and right knee pain. The injured worker was diagnosed as having lumbago, cervicgia, and pain in joint lower leg. Treatment to date has included an anterior posterior fusion from L3-S1 (2007), epidural injection (2014), physical therapy, MRI and CT scans. Currently, the injured worker complains of significant pain in the back with numbness and tingling in the buttocks and down her legs. She has received physical therapy, an intrathecal morphine pump (removed due to infection and development of spinal meningitis), medication therapy, a spinal cord stimulator (removed due to lead migration and ineffectiveness); trigger point injections and a right total knee arthroplasty (10/2013). The plan of treatment is for further back surgery. A request for authorization was submitted for: Lumbar L1-L2, L2-L3 Direct Lateral Fusion/ Revision (Thoracic) T10-S1 (Sacroiliac); Inpatient stay, 3 days, Assistant; Spinal cord monitoring/ history and physical for Labs/Clearance (CBC complete blood count with diff, CMP complete metabolic panel, PT prothrombin time, PTT partial thromboplastin time, UA urinalysis, Chest X-ray, EKG electrocardiogram); and LSO (lumbosacral) Brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar L1-L2, L2-L3 Direct Lateral Fusion/ Revision (Thoracic) T10-S1 (Sacroiliac):
Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305 and 307.

Decision rationale: The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation shows this patient has been complaining of pain in the back and knee. Documentation does not disclose disabling lower extremity symptoms. The guidelines also list the necessity for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The requested treatment is for a direct lateral and revision of previous fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. Requested Treatment: Lumbar L1-L2, L2-L3 Direct Lateral Fusion/ Revision (Thoracic) T10-S1 (Sacroiliac) is not medically necessary and appropriate.

Inpatient stay, 3 days: Upheld

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

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: 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.

Spinal cord monitoring/ history and physical for Labs/Clearance (CBC complete blood count with diff, CMP complete metabolic panel, PT prothrombin time, PTT partial thromboplastin time, UA urinalysis, chest x-ray, EKG electrocardiogram): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Preoperative Testing.

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.

LSO (lumbosacral) Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Procedure Summary.

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.