MAXIMUS Federal Services

Case Number:	CM15-0059620		
Date Assigned:	04/14/2015	Date of Injury:	11/23/1999
Decision Date:	05/07/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	03/30/2015

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 is a 51 year old male, who sustained an industrial injury on November 23, 1999. The injured worker had reported low back pain. The diagnoses have included lumbar radiculopathy with new onset of left foot drop in 2013, discogenic pain, chronic lumbar radiculitis, anxiety and depression. Treatment to date has included medications, radiological studies, physical therapy, injections and lumbar surgery, IDET in February 2004, global fusion L4-5 7/1/2005, X-LIF L3-4 with lateral plating 7/29/08, extension of fusion and hardware revision, removal 4/5/12 and hardware removal L3-4 02/06/2014. Current documentation dated February 19, 2015 notes that the injured worker reported upper and lower back pain with radiation to the bilateral lower extremities. The injured worker also noted muscle spasms of the paravertebral area, bilateral lower extremity weakness and hip pain. Physical examination revealed decreased strength and sensation in the left leg. A Faber's test was positive bilaterally. The treating physician's plan of care included a request for L2-3 lateral lumbar interbody posterior fusion with instrumentation and intra-operative monitoring, assistant surgeon, inpatient 2 day stay, pre-operative examination, pre-operative labs, EKG and chest x-ray, lumbar brace, Vascutherm cold therapy unit 14 day rental, post-operative physical therapy and Orthofix.

IMR ISSUES, DECISIONS AND RATIONALES

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

L2-3 XLIF posterior fusion with instrumentation and intra-operative monitoring: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th Edition (web), 215, Low Back Chapter: Fusion, spinal, endoscopic.

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

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 chronic pain in the upper and lower back. Documentation does not disclose new disabling lower extremity symptoms. In fact the office note of 9/22/2014 stated his pain had reduced to 3-6/10. The guidelines also list the criteria 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 physical examination data indicate persisting left leg strength at 4/5. The requested treatment is for a XLIF posterior fusion with instrumentation. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: L2-3 XLIF posterior fusion with instrumentation and intra-operative monitoring is not medically necessary and appropriate.

Associated surgical service: Assistant surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment Index, 13th Edition (web), 2015, Low Back Chapter: Fusion, (spinal), Fusion, endoscopic.

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: Inpatient 2 day stay: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment Index, 13th Edition (web), 2015, Low Back Chapter: Fusion (spinal), Fusion, endoscopic.

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-op Exam: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment Index, 13th Edition (web), 2015, Low Back Chapter: Fusion, (spinal), Fusion, endoscopic.

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: CBC with diff, CMP, PT, PTT, UA and EKG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th Edition (web), 2015, Low Back Chapter: Fusion (spinal), fusion, endoscopic.

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: Lumbar Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th Edition (web), 2015, Low Back Chapter: Fusion (spinal), Fusion, endoscopic.

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: Vascutherm Cold Therapy Unit 14 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment Index, 13th Edition (web), 2015, Low Back Chapter: Fusion, (spinal), Fusion, endoscopic.

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.

Post-op Physical Therapy 2 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment Index, 13th Edition (web), 2015, Low Back Chapter: Fusion, (spinal), Fusion, endoscopic.

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: Orthofix: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment Index, 13th Edition (web), 2015, Low Back Chapter: Fusion, (spinal), Fusion, endoscopic.

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-op 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); Treatment Index, 13th Edition (web), 2015, Low Back Chapter: Fusion, (spinal), Fusion, endoscopic.

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.