

Case Number:	CM14-0148838		
Date Assigned:	09/18/2014	Date of Injury:	05/05/1994
Decision Date:	11/03/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/12/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 63-year old female who injured her low back on 05/05/94. The medical records provided for review documented that the claimant has a complex surgical history of the lumbar spine including multiple prior fusions. There was evidence of an interbody fusion from L2 through L5 and posterior fusion from T10 through L2. Most recently the claimant underwent an L5-S1 transforaminal interbody fusion at L5-S1 with removal of prior hardware. The progress report dated 08/13/14 described continued low back pain and difficulty with ambulation. Physical examination revealed musculoskeletal tenderness to palpation, an antalgic gait pattern, pain from the T12 to sacral level on palpation and restricted range of motion. Neurologic examination showed motor strength at 3/5 to the hip flexors on the right and 4/5 on the left and hip abductor strength 4+/5 bilaterally. There were equal and symmetrical deep tendon reflexes. Reviewed at that time were a prior lumbar MRI and CT scan that showed no significant compressive pathology, with evidence of prior instrumentation from T10 through L2, as well as L4 through S1. Given the claimant's pain complaints, the recommendation was made for an L3 pedicle subtraction osteotomy. There was no documentation of L3 clinical findings noted on imaging.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3 Pedicle Subtraction Osteotomy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines (ODG), Low Back chapter

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

Decision rationale: Based on the California ACOEM Guidelines, the request for pedicle screw subtraction osteotomy at L3 is not recommended as medically necessary. Presently, there is no indication for the need for further surgical intervention of the claimant's lumbar spine based on lumbar spine imaging. There is specifically no documentation of compressive pathology or clinical findings related to the claimant's L3 level. Given the claimant's clinical presentation of multiple prior surgeries without documentation of specific pathology of claimant's L3 level, the request for further operative intervention in the form of a Pedicle Screw Subtraction Osteotomy at L3 is not medically necessary.