

Case Number:	CM15-0018454		
Date Assigned:	02/06/2015	Date of Injury:	09/20/1991
Decision Date:	03/30/2015	UR Denial Date:	01/01/2015
Priority:	Standard	Application Received:	01/30/2015

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: Texas
 Certification(s)/Specialty: Orthopedic 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 54-year-old female who reported an injury on 09/20/1991. The mechanism of injury was not specifically stated. The current diagnosis is scoliosis. The injured worker presented on 07//22/2014 for an initial orthopedic consultation. It was noted that the injured worker had progression of scoliosis and kyphosis with worsening back and bilateral leg pain. The injured worker utilized a walker and a cane for ambulation assistance. The current medication regimen includes methadone, oxycodone, gabapentin, Prozac, and Lamictal. Upon examination, there was significant kyphotic deformity at the thoracolumbar junction, tenderness to palpation, 1+ Achilles and patellar reflexes, absent Babinski bilaterally, 5/5 motor strength, negative straight leg raise, and negative slump test. X-rays obtained in the office revealed thoracolumbar scoliosis with a Cobb angle of 60 degrees and a kyphotic deformity with a Cobb angle of 63 degrees suspicious for Scheuermann's disease. It was noted that the injured worker had been able to manage her pain over the years with conservative therapy; however, the pain and disability were significantly impacting the injured worker's quality of life and she was now interested in surgical correction. Recommendations included an anterior release/posterior spinal decompression/fusion/instrumentation from T4 to the pelvis to correct scoliosis and kyphosis. The injured worker was referred for an MRI of the thoracic spine and lumbar spine. A Request for Authorization form was then submitted on 12/24/2014 for the requested surgical procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fusion Lumbar Anterior Release L1-5, Stage 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. 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, the injured worker reports low back pain with radicular symptoms. However, the physical examination reveals 5/5 bilateral lower extremities strength with a negative straight leg raise. Additionally, there was no documentation of psychosocial clearance prior to the request for a lumbar fusion. Flexion and extension view x-rays were not provided, documenting evidence of spinal instability. Given the above, the request is not medically appropriate in this case.

Fusion Thoracic Posterior T4-Pelvis, Fusion Lumbar Posterior, Stage 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. 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, the injured worker reports low back pain with radicular symptoms. However, the physical examination reveals 5/5 bilateral lower extremities strength with a negative straight leg raise. Additionally, there was no documentation of psychosocial clearance prior to the request for a lumbar fusion.

Flexion and extension view x-rays were not provided, documenting evidence of spinal instability. Given the above, the request is not medically appropriate in this case.

Facility: 14 Inpatient Days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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.