

Case Number:	CM15-0176570		
Date Assigned:	09/28/2015	Date of Injury:	12/03/2003
Decision Date:	11/19/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/08/2015

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, Montana, 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 57 year old male who sustained an industrial injury on December 03, 2003. A recent primary treating office visit dated July 27, 2015 noted the plan of care with requested recommendation for a T9-L1 posterior spinal instrumentation and fusion, with possible removal of hardware at T8-9. He will require a TLSO brace, pneumatic intermittent compression device, post-operative physiotherapy three times a week for six weeks, and pre-operative medical clearance, chest radiography. "He has had a diagnostic block, follow up radiofrequency ablation; failed conservative measures, including abundant physical therapy." Primary office visit dated July 10, 2015 reported subjective complaint of "left sided mid to low back pain that wraps around the stomach" which he rates a "8 out of 10" in intensity with medication. Current medications consisted of: Nexium, Norco, Zolof, and Ativan. The assessment found the worker with: left knee degenerative joint disease; status post fusion thoracic; status post lumbar fusion with residual left leg numbness; disc degeneration (non-industrial), and thoracic left facet arthropathy, industrial related confirmed by diagnostic facet blocks. On August 20, 2015, a request was made for chest radiography and post-operative physiotherapy session, which was non-certified on August 25, 2015 by Utilization Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 T9-L1 Posterior spinal instrumentation and fusion, removal of hardware at T8-T9 with intraoperative spinal cord monitoring: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar and Thoracic Fusion (spinal).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Spinal fusion chapter-Hardware removal.

Decision rationale: California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of this. No evidence is provided for instability, which could be construed as a rationale for a thoracic lumbar fusion. The ODG guidelines do recommend removal of hardware if it is broken or found to be a pain generator. Documentation does not show the instrumentation is broken or a pain generator. The California MTUS guidelines do recommend spinal surgery if there is clear clinical, electrophysiological and imaging evidence of nerve impingement, which would correlate with severe, debilitating pain unresponsive to conservative management. Documentation does not provide this evidence. The requested treatment: 1 T9-L1 Posterior spinal instrumentation and fusion, removal of hardware at T8-T9 with intraoperative spinal cord monitoring is not medically necessary and appropriate.

1 Pre-operative medical clearance: 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.

Associated surgical service: 1 Assistant surgeon: 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.

Associated surgical services: 2 Days inpatient stay: Upheld

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Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hospital length of stay (LOS).

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 services: 1 Chest X-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar and Thoracic Chapter.

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.

9 Post-operative physiotherapy visits: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

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 services: 1 Pneumatic intermittent compression device: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg.

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 services: Lumbar-sacral orthosis (LSO) brace: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar and Thoracic Lumbar supports.

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 services: 1 Orthofix Bone Growth Stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter.

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.