

Case Number:	CM15-0061505		
Date Assigned:	04/07/2015	Date of Injury:	08/13/2014
Decision Date:	05/27/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	04/01/2015

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 62-year-old female with an industrial injury dated August 13, 2014. The mechanism of injury involved a fall. The diagnoses include L1-L2 severe disc degeneration, L2-L3 disc degeneration with left lateral listhesis, L3-L4 disc degeneration with mild lateral listhesis, L4-L5 grade II anterior spondylolisthesis with disc and facet degeneration, lumbar degenerative scoliosis, thoracic disc degeneration and history of reaction to absorbable sutures. Treatment has consisted of diagnostic studies, prescribed medications, physical therapy and periodic follow up visits. According to the treating physician report dated 03/02/2015, the injured worker reported severe persisting low back pain and her decision to proceed with surgery. There was no comprehensive physical examination provided on the requesting date; however, the physician indicated the injured worker demonstrated difficulty rising from a seated position. The strength in the bilateral lower extremities did not show focal deficit. Treatment recommendations at that time included surgical intervention at the L1-5 levels. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Direct Lateral Fusion L1-L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

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, there was no evidence of a recent exhaustion of all conservative treatment prior to the request for surgical intervention. Guidelines recommend a spinal fusion for pathology that is limited to only 2 levels. There is no documentation of spinal instability at the requested levels upon flexion and extension view x-rays. In addition, there was no documentation of a psychosocial screening prior to the request for a lumbar fusion. Given the above, the request is not medically necessary.

Posterior Fusion L1-S1 Staged over 2 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

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, there was no evidence of a recent exhaustion of all conservative treatment prior to the request for surgical intervention. Guidelines recommend a spinal fusion for pathology that is limited to only 2 levels. There is no documentation of spinal instability at the requested levels upon flexion and extension view x-rays. In addition, there was no documentation of a psychosocial screening prior to the request for a lumbar fusion. Given the above, the request is not medically necessary.

Associated Surgical Services: Inpatient Stay (3-days): 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.

Pre-Operative CXR, EKG, CBC, CMP, PT, PTT, UA: 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.