

Case Number:	CM15-0062914		
Date Assigned:	04/08/2015	Date of Injury:	04/15/2008
Decision Date:	05/11/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/02/2015

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 year old male, who sustained an industrial injury on April 15, 2008, incurring back injuries. He was diagnosed with lumbar degenerative disc disease with radiculopathy, lumbar herniation and osteoarthritis. He underwent a laminectomy and fusion on 4/19/14. Currently, on 3/13/15, the injured worker complained of ongoing back pain and tenderness. The treatment plan that was requested for authorization included a transforaminal lumbar fusion, lumbosacral removal and exploration, a possible lumbosacral revision, a posterior spinal fusion, surgical assistant and a three day inpatient stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-S1 remove and explore: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Spinal fusion chapter-Hardware removal.

Decision rationale: The ODG guidelines do recommend hardware removal if the hardware is broken or infected or if the hardware has been shown to be a pain generator. The report of the MRI scan of 10/29/14 and the spine x-rays in flexion and extension do not mention any breakage or infection. The AME's comment of 11/25/14 was that the scan showed "perfectly normal" post-operative imaging study. The documentation does not provide evidence the hardware is a pain generator. The requested treatment: L3-S1 remove and explore is NOT medically necessary and appropriate.

L5-S1 possible revision: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) spinal fusion chapter-hardware removal and Other Medical Treatment Guidelines. Since the requested treatment: L3-S1 remove and explore is NOT medically necessary and appropriate, then the requested treatment: L5-S1 possible revision is NOT medically necessary and appropriate.

Decision rationale: Since the requested treatment: L3-S1 remove and explore is NOT Medically necessary and appropriate, then the requested treatment: L5-S1 possible revision is NOT Medically necessary and appropriate. The ODG guidelines do recommend hardware removal if the hardware is broken or infected or if the hardware has been shown to be a pain generator. The report of the MRI scan of 10/29/14 and the spine x-rays in flexion and extension do not mention any breakage or infection. The AME's comment of 11/25/14 was that the scan showed "perfectly normal" post-operative imaging study. The documentation does not provide evidence the hardware is a pain generator.

Transforaminal lumbar interbody fusion (FLIF) at L3-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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 pain in the back. Documentation does not disclose disabling lower extremity symptoms. 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 requested treatment is for a lumbar interbody fusion. The guidelines note that the efficacy

of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: Transforaminal lumbar interbody fusion (FLIF) at L3-S1 is NOT medically necessary and appropriate.

Posterior spinal fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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 pain in the back. Documentation does not disclose disabling lower extremity symptoms. 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 MRI scan report of 10/29/14 does not report any failure of fusion or instability. The requested treatment is for a posterior spinal fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: Transforaminal lumbar interbody fusion is NOT Medically necessary and appropriate.

Surgical assistant: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Transforaminal lumbar interbody fusion (FLIF) at L3-S1 is NOT medically necessary and appropriate, then the requested treatment: Surgical assistant is NOT medically necessary and appropriate.

Decision rationale: Since the requested treatment: Transforaminal lumbar interbody fusion (FLIF) at L3-S1 is NOT medically necessary and appropriate, then the requested treatment: Surgical assistant is NOT medically necessary and appropriate.

3 day inpatient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: Transforaminal lumbar interbody fusion (FLIF) at L3-S1 is NOT Medically necessary and appropriate, then the requested treatment: 3 day inpatient stay Is NOT medically necessary and appropriate.

Decision rationale: The Expert Reviewer based his/her decision on the Non-MTUS Since the requested treatment: Transforaminal lumbar interbody fusion (FLIF) at L3-S1 is NOT medically necessary and appropriate, then the requested treatment: 3 day inpatient stay is NOT medically necessary and appropriate.