

Case Number:	CM15-0097962		
Date Assigned:	05/29/2015	Date of Injury:	01/12/2012
Decision Date:	07/01/2015	UR Denial Date:	05/07/2015
Priority:	Standard	Application Received:	05/20/2015

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 58 year old male, who sustained an industrial injury on 1/12/2012. He reported low back pain after being hit by a door. The injured worker was diagnosed as having lumbar spinal stenosis, and lumbar or lumbosacral intervertebral disc degeneration, nonunion of posterior fusion, spondylolisthesis, severe disc space collapse, and neurogenic claudication. He has a history of 3 back surgeries (first at age 23, second at age 25 and third at age 44). Treatment to date has included medications, x-rays, electrodiagnostic studies, magnetic resonance imaging of the lumbar spine (6/7/2012), physical therapy, and activity modification. The request is for lumbar fusion at L3-4, L4-5 and L5-S1 and decompression at L4-S1; 5 day inpatient hospital stay; pre-operative laboratory work; per-operative electrocardiogram; pre-operative examination; and posterior fusion at L3-S1 with instrumentation. On 4/17/2015, he is reported to have had a facet block and is returning for follow up examination. He reported attaining 40% relief of pain from the facet block. Physical findings noted some improvement when compared to pre-injection examination, otherwise it is unchanged. He is noted to have an abnormal gait on the right, increased sensitivity in the L4 dermatome on the right and a positive straight leg raise test on the right. A CT scan is reported to have been done on 2/6/2015, and revealed the T12-L1 and L3-4 facet joints as normal. The provider disagreed with the CT scan findings and reported that reconstruction showed subchondral cysts in the facet joints at L3-4 and gapping of the joint, retrolisthesis of L3 on L4, extreme narrowing of the L4-5 disc space with extreme facet arthropathy and anterolisthesis at L4-5, and a vacuum sign at L4-5 on flexion and extension. The provider reported that a magnetic resonance imaging of the lumbar spine dated 1/23/2015,

showed severe foraminal stenosis at L4-5. He is noted to have had 100% recovering of lumbar fusion at L5-S1 completed in 1980. The treatment plan included: lumbar surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

First stage: Anterior lumbar fusion L3-4, L4-5 and L5-S1 decompression L4-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: First stage: Anterior lumbar fusion L3-4, L4-5 and L5-S1 decompression L4-S1 is not medically necessary and appropriate.

Inpatient hospital stay, 5 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.

Preoperative CBC (complete blood count), UA (urinalysis) and CHEM 8 (basic metabolic panel): 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.

Preoperative EKG (electrocardiogram): 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.

Preoperative examination: 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.

Second Stage: Posterior fusion L3-S1 with instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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 flexion or extension views of his lumbar spine which demonstrate pathologic instability. Documentation does not provide evidence of the location of a pain generator. The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Second Stage: Posterior fusion L3-S1 with instrumentation is not medically necessary and appropriate.