

Case Number:	CM13-0003529		
Date Assigned:	03/03/2014	Date of Injury:	12/25/2012
Decision Date:	04/11/2014	UR Denial Date:	07/15/2013
Priority:	Standard	Application Received:	07/25/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Spine Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 47-year-old male with a 12/25/12 date of injury. At the time (6/27/13) of request for authorization for L4-L5 transforaminal lumbar interbody fusion, L4-L5 posterior fusion, posterior fusion with instrumentation, lumbar back brace, 1 box island bandage 4x10, and post-operative physical therapy sessions #18, there is documentation of subjective (low back pain radiating down the right leg with associated numbness and tingling, as well as partial foot drop with weakness) and objective (3/5 weakness Final Determination Letter for IMR Case Number CM13-0003529 3 of right dorsiflexion and numbness in the L5 distribution on the right) findings, imaging findings (lumbar MRI (3/26/13) report revealed a 5 mm right-sided disk protrusion noted at the L4-L5 level, which encroaches upon the ventral aspect of the thecal sac, the right-sided intrathecal nerve roots, as well as the descending right L5 nerve root within the spinal canal), current diagnoses (lumbar spinal stenosis with right lower extremity radiculopathy), and treatment to date (physical therapy, chiropractic therapy, activity modification, and medication). There is no documentation of a condition/diagnosis for which fusion is indicated (instability OR a statement that decompression will create surgically induced instability).

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 TRANSFORAMINAL LUMBAR INTERBODY FUSION.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 305-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK, DISCECTOMY/LAMINECTOMY AND FUSION (SPINAL).

Decision rationale: MTUS reference to ACOEM identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Failure of conservative treatment; and an Indication for fusion (instability OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminectomy/fusion. ODG identifies documentation of Symptoms/Findings, which confirm presence of radiculopathy, objective findings that correlate with symptoms and imaging findings in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression/laminectomy. Within the medical information available for review, there is documentation of a diagnosis of lumbar spinal stenosis with right lower extremity radiculopathy. In addition, there is documentation of subjective (pain) and objective (sensory changes) radicular findings in the requested nerve root distribution, imaging (MRI) findings (nerve root compression) at the requested level, and failure of conservative treatment (activity modification, medications, and physical modalities). However, there is no documentation of a condition/diagnosis for which fusion is indicated (instability OR a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for L4-L5 transforaminal lumbar interbody fusion is not medically necessary

L4-L5 POSTERIOR FUSION.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 305-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK, DISCECTOMY/LAMINECTOMY AND FUSION (SPINAL).

Decision rationale: MTUS reference to ACOEM identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Failure of conservative treatment; and an Indication for fusion (instability OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminectomy/fusion. ODG identifies documentation of Symptoms/Findings, which confirm presence of radiculopathy, objective findings that correlate with symptoms and imaging findings in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the

medical necessity of decompression/laminectomy. Within the medical information available for review, there is documentation of a diagnosis of lumbar spinal stenosis with right lower extremity radiculopathy. In addition, there is documentation of subjective (pain) and objective (sensory changes) radicular findings in the requested nerve root distribution, imaging (MRI) findings (nerve root compression) at the requested level, and failure of conservative treatment (activity modification, medications, and physical modalities). However, there is no documentation of a condition/diagnosis for which fusion is indicated (instability OR a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for L4-L5 posterior fusion is not medically necessary.

POSTERIOR FUSION WITH INSTRUMENTATION.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 305-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK, DISCECTOMY/LAMINECTOMY AND FUSION (SPINAL).

Decision rationale: MTUS reference to ACOEM identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Failure of conservative treatment; and an Indication for fusion (instability OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminectomy/fusion. ODG identifies documentation of Symptoms/Findings, which confirm presence of radiculopathy, objective findings that correlate with symptoms and imaging findings in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression/laminectomy. Within the medical information available for review, there is documentation of a diagnosis of lumbar spinal stenosis with right lower extremity radiculopathy. Final Determination Letter for IMR Case Number CM13-0003529 5 In addition, there is documentation of subjective (pain) and objective (sensory changes) radicular findings in the requested nerve root distribution, imaging (MRI) findings (nerve root compression) at the requested level, and failure of conservative treatment (activity modification, medications, and physical modalities). However, there is no documentation of a condition/diagnosis for which fusion is indicated (instability OR a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for posterior fusion with instrumentation is not medically necessary.

LUMBAR BACK BRACE.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES: LOW BACK 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.

1 BOX ISLAND BANDAGE 4X10: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CONVATEC. SOLUTIONS[®] WOUND CARE ALGORITHM, PRINCETON (NJ): CONVA TEC; 200. 8P

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.

POST-OPERATIVE PHYSICAL THERAPY SESSIONS #18: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical 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.