

Case Number:	CM13-0006198		
Date Assigned:	12/27/2013	Date of Injury:	01/07/2001
Decision Date:	03/11/2014	UR Denial Date:	07/16/2013
Priority:	Standard	Application Received:	08/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic 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 physician 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:

The patient is a 61-year-old male who reported an injury on 01/07/2001. The mechanism of injury was not provided. The patient was noted to have an MRI of the lumbar spine without contrast on 06/06/2013, which revealed that there was narrowing of the disc space, with posterior spurring and bulging at multiple levels. The canal was noted to be most significantly narrowed at L4-5 and 3-4 levels. There was noted to be lateral recess narrowing at L4-5 left greater than right. There was noted to be mild retrolisthesis of L4 relative to L5 that was seen with narrowing of the foramina, left greater than right, similar to previous examination. There were noted to be degenerative changes at other levels. At the level of L5-S1, there was noted to be posterior spurring and bulging causing several mm of encroachment on the thecal sac with mild degenerative changes of the facets. The physical examination revealed that the patient had pain radiating down the right leg and hip. The pain was noted to be severe. The symptoms were noted to be aching and tingling. The neurologic examination revealed that the patient had left knee extension strength of 4-/5; left ankle dorsiflexion strength of 4+/5, and sensation to touch that was noted to be decreased on the left at the L4 dermatome. The patient was noted to have a previous hip replacement. The patient was noted to have a positive straight leg raise on the left and a Kemp's test that was positive bilaterally. The diagnoses were noted to be backache, pain in the low back, lumbar degenerative disc disease, sciatica, lumbar radiculopathy, degenerative joint disease of the spine, and spinal stenosis with neurogenic claudication, with walking limited to 200 feet. The request was made for an arthrodesis posterior interbody with laminectomy, hemilaminectomy, pedicle 1 interspace application intervertebral biomechanical device to vertebral defect, fluoroscopic guidance for needle and level marking, autograft spine surgery local same incision, allograft spine surgery only morselized, assistant surgeon, three (3) days inpatient stay, and cardiac clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral for cardiac clearance prior to lumbar surgery: 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6, Page 163.

Decision rationale: The ACOEM Guidelines indicate that consultation is intended to aid in assessing the diagnosis, prognosis, and therapeutic management, determination of medical stability and permanent residual loss, and/or examinees fitness for return to work. However, per the patient's history, there was lack of documentation indicating that the patient had cardiac risk factors and there was lack of documentation indicating rationale for a preoperative cardiac clearance. The surgery was not supported and there was a lack of documentation of exceptional factors to support the necessity for a cardiac clearance. This request would not be supported. Given the above, the request for referral for cardiac clearance prior to lumbar surgery is not medically necessary.

Posterior interbody arthrodesis with laminectomy L2-3, L4-5: Upheld

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

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

Decision rationale: The MTUS/ACOEM Guidelines indicate that a surgical consultation is for patients who have severe and disabling lower leg symptoms in a 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 (1) month, or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short-term and long-term from surgical repair, and a failure of conservative treatment to resolve disabling radicular symptoms. It further indicates that the surgical treatment for spinal stenosis is a laminectomy. Additionally, a spinal fusion is not generally considered during the first three (3) months of symptoms. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis can be candidates for fusion. The clinical documentation submitted for review indicated that the patient's diagnoses included spinal stenosis with neurogenic claudication with walking limited to 200 feet. The patient was noted to have a moderately decreased range of motion. The patient was noted to have a straight leg raise in the sitting position that was positive on the left along with bilateral facet loading that was positive. The patient was noted to be using

a four wheeled walker. The patient's neurologic examination revealed that the left knee extension strength to demonstrate L3 was 4-/5, left ankle dorsiflexion strength at L4 was 4+/5 and sensation was noted to be decreased on the left in the L4 dermatome. The MRI indicated that the patient had narrowing of the disc space with posterior spurring and bulging at multiple levels and the canal was noted to be narrowed at L4-5 and L3-4. There was noted to be lateral recess narrowing at L4-5 left greater than right. The patient was noted to have mild retrolisthesis of L4-5 with narrowing of the foramina left greater than right and degenerative changes that were seen at other levels. The clinical documentation submitted for review indicated that the patient had a hip replacement on the left and the patient's neurologic findings and MRI findings were noted to be on the left, which could possibly be contributed to the patient's hip replacement, if weakness exists in the left hip or if there was nerve injury in the left hip. However, there was lack of documentation upon physical examination, as well as MRI findings to indicate that the patient had spinal stenosis and instability at the requested level. There was a lack of documentation of a recent objective physical examination. Additionally, the findings on the MRI were noted to be on the left. Given the above, the request for a posterior interbody arthrodesis with laminectomy at L2-3, L4-5 is not medically necessary.

Hemi-laminotomy, one (1) interspace, posterior non-segmental instrumentation: Upheld

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

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

Decision rationale: The MTUS/ACOEM Guidelines indicate that a surgical consultation is for patients who have severe and disabling lower leg symptoms in a 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 (1) month, or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short-term and long-term from surgical repair, and a failure of conservative treatment to resolve disabling radicular symptoms. It further indicates that the surgical treatment for spinal stenosis is a laminectomy. Additionally, a spinal fusion is not generally considered during the first three (3) months of symptoms. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis can be candidates for fusion. The clinical documentation submitted for review indicated that the patient's diagnoses included spinal stenosis with neurogenic claudication with walking limited to 200 feet. The patient was noted to have a moderately decreased range of motion. The patient was noted to have a straight leg raise in the sitting position that was positive on the left along with bilateral facet loading that was positive. The patient was noted to be using a four wheeled walker. The patient's neurologic examination revealed the left knee extension strength to demonstrate L3 was 4-/5, left ankle dorsiflexion strength at L4 was 4+/5 and sensation was noted to be decreased on the left in the L4 dermatome. The MRI indicated that the patient had narrowing of the disc space with posterior spurring and bulging at multiple levels and the canal was noted to be narrowed at L4-5 and L3-4. There was noted to be lateral recess narrowing at L4-5 left greater than right. The patient was noted to have mild retrolisthesis of L4-

5 with narrowing of the foramina left greater than right and degenerative changes that were seen at other levels. The clinical documentation submitted for review indicated the patient had a hip replacement on the left and the patient's neurologic findings and MRI findings were noted to be on the left, which could possibly be contributed to the patient's hip replacement, if weakness exists in the left hip or if there was nerve injury in the left hip. However, there was lack of documentation upon physical examination, as well as MRI findings to indicate that the patient had spinal stenosis and instability at the requested level. There was a lack of documentation of a recent objective physical examination. Additionally, the findings on the MRI were noted to be on the left. Given the above, the request for a posterior interbody arthrodesis with laminectomy at L2-3, L4-5 is not medically necessary.

Pedicle one (1) interspace, application intervertebral biomechanical device to vertebral defect: Upheld

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

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

Decision rationale: The MTUS/ACOEM Guidelines indicate that a surgical consultation is for patients who have severe and disabling lower leg symptoms in a 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 (1) month, or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short-term and long-term from surgical repair, and a failure of conservative treatment to resolve disabling radicular symptoms. It further indicates that the surgical treatment for spinal stenosis is a laminectomy. Additionally a spinal fusion is not generally considered during the first three (3) months of symptoms. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis can be candidates for fusion. The clinical documentation submitted for review indicated that the patient's diagnoses included spinal stenosis with neurogenic claudication with walking limited to 200 feet. The patient was noted to have a moderately decreased range of motion. The patient was noted to have a straight leg raise in the sitting position that was positive on the left along with bilateral facet loading that was positive. The patient was noted to be using a 4 wheeled walker. The patient's neurologic examination revealed the left knee extension strength to demonstrate L3 was 4-/5, left ankle dorsiflexion strength at L4 was 4+/5 and sensation was noted to be decreased on the left in the L4 dermatome. The MRI indicated that the patient had narrowing of the disc space with posterior spurring and bulging at multiple levels and the canal was noted to be narrowed at L4-5 and L3-4. There was noted to be lateral recess narrowing at L4-5 left greater than right. The patient was noted to have mild retrolisthesis of L4-5 with narrowing of the foramina left greater than right and degenerative changes that were seen at other levels. The clinical documentation submitted for review indicated that the patient had a hip replacement on the left and the patient's neurologic findings and MRI findings were noted to be on the left, which could possibly be contributed to the patient's hip replacement, if weakness exists in the left hip or if there was nerve injury in the left hip. However, there was lack of

documentation upon physical examination, as well as MRI findings to indicate that the patient had spinal stenosis and instability at the requested level. There was a lack of documentation of a recent objective physical examination. Additionally, the findings on the MRI were noted to be on the left. Given the above, the request for a posterior interbody arthrodesis with laminectomy at L2-3, L4-5 is not medically necessary.

Fluoroscopic guidance for needle/ level marking: 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.

Autograft, spine surgery - local- same incision: 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.

Allograft spine surgery only- morselized: 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 Official Disability Guidelines (ODG), Low Back Chapter, Transplantation, intervertebral disc

Decision rationale: The Official Disability Guidelines do not recommend transplantation of an intervertebral disc, allograft until further research is completed. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. As such, the request for allograft spine surgery only morselized is not medically necessary.

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.

Three (3) days of 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 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.