MAXIMUS Federal Services

Case Number:	CM13-0024690		
Date Assigned:	12/18/2013	Date of Injury:	12/10/2011
Decision Date:	03/28/2014	UR Denial Date:	09/03/2013
Priority:	Standard	Application Received:	09/16/2013

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, has a subspecialty Spine Surgery, and is licensed to practice in Texas and 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 52-year-old who reported an injury on 12/10/2011. The mechanism of injury involved heavy lifting. The patient is currently diagnosed with degenerative disc disease with retrolisthesis and central disc herniation at L4-5. The patient was seen by [redacted] on 08/15/2013. The patient reported constant lower back pain with radiation to bilateral lower extremities. Physical examination revealed normal gait, decreased range of motion, intact motor and sensory function of bilateral lower extremities, and decreased sensation in the lateral thighs. Treatment recommendations included an L4-5 decompression and spinal fusion with posterior bilateral L4-5 laminotomy and interspinous instrumented fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Allograft, morselized, or placement of osteopromotive material, for spine surgery: 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 Physician Reviewer's decision rationale: The Low Back Complaints Chapter of the ACOEM Practice Guidelines state referral for surgical consultation is indicated

for patients who have severe and disabling lower extremity symptoms, activity limitation due to radiating pain for more than 1 month, extreme progression of symptoms, clear clinical, imaging and electrophysiological evidence of a lesion, and a failure of conservative treatment. As per the documentation submitted, there was no evidence of radiculopathy upon physical examination. The physician noted intact motor and sensory function to bilateral lower extremities with only a decrease in sensation to the lateral thighs bilaterally. There were no imaging studies or electrodiagnostic reports submitted for review. There is no evidence of documented instability on flexion and extension view radiographs. There has not been a psychological evaluation prior to the requested surgical intervention. Additionally, there is no evidence of an exhaustion of conservative treatment. The request for Allograft, morselized, or placement of osteopromotive material, for spine surgery, is not medically necessary or appropriate.

Autograft for spine surgery only: 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 Physician Reviewer's decision rationale: The Low Back Complaints Chapter of the ACOEM Practice Guidelines state referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation due to radiating pain for more than 1 month, extreme progression of symptoms, clear clinical, imaging and electrophysiological evidence of a lesion, and a failure of conservative treatment. As per the documentation submitted, there was no evidence of radiculopathy upon physical examination. The physician noted intact motor and sensory function to bilateral lower extremities with only a decrease in sensation to the lateral thighs bilaterally. There were no imaging studies or electrodiagnostic reports submitted for review. There is no evidence of documented instability on flexion and extension view radiographs. There has not been a psychological evaluation prior to the requested surgical intervention. Additionally, there is no evidence of an exhaustion of conservative treatment. The request for autograft for spine surgery only is not medically necessary or appropriate.

Lumbar lateral interbody fusion (XLIF) at [redacted]: 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 Low Back Complaints Chapter of the ACOEM Practice Guidelines state referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation due to radiating pain for more than one month, extreme progression of symptoms, clear clinical, imaging and electrophysiological evidence of a

lesion, and a failure of conservative treatment. As per the documentation submitted, there was no evidence of radiculopathy upon physical examination. The physician noted intact motor and sensory function to bilateral lower extremities with only a decrease in sensation to the lateral thighs bilaterally. There were no imaging studies or electrodiagnostic reports submitted for review. There is no evidence of documented instability on flexion and extension view radiographs. There has not been a psychological evaluation prior to the requested surgical intervention. Additionally, there is no evidence of an exhaustion of conservative treatment. The request for lumbar lateral interbody fusion (XLIF) at [redacted] is not medically necessary or appropriate.

Arthrodesis, anterior interbody technique: 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 Physician Reviewer's decision rationale: The Low Back Complaints Chapter of the ACOEM Practice Guidelines state referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation due to radiating pain for more than one month, extreme progression of symptoms, clear clinical, imaging and electrophysiological evidence of a lesion, and a failure of conservative treatment. As per the documentation submitted, there was no evidence of radiculopathy upon physical examination. The physician noted intact motor and sensory function to bilateral lower extremities with only a decrease in sensation to the lateral thighs bilaterally. There were no imaging studies or electrodiagnostic reports submitted for review. There is no evidence of documented instability on flexion and extension view radiographs. There has not been a psychological evaluation prior to the requested surgical intervention. Additionally, there is no evidence of an exhaustion of conservative treatment. The request for arthrodesis, anterior interbody technique is not medically necessary or appropriate.

Posterior bilateral L4-L5 laminectomy and interspinous instrumented fusion at l4-l5: 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 Low Back Complaints Chapter of the ACOEM Practice Guidelines state referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation due to radiating pain for more than one month, extreme progression of symptoms, clear clinical, imaging and electrophysiological evidence of a lesion, and a failure of conservative treatment. As per the documentation submitted, there was

no evidence of radiculopathy upon physical examination. The physician noted intact motor and sensory function to bilateral lower extremities with only a decrease in sensation to the lateral thighs bilaterally. There were no imaging studies or electrodiagnostic reports submitted for review. There is no evidence of documented instability on flexion and extension view radiographs. There has not been a psychological evaluation prior to the requested surgical intervention. Additionally, there is no evidence of an exhaustion of conservative treatment. The request for posterior bilateral L4-L5 laminectomy and interspinous instrumented fusion at l4-l5 is not medically necessary or appropriate.

Posterior segmental instrumentation: 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 Low Back Complaints Chapter of the ACOEM Practice Guidelines state referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation due to radiating pain for more than one month, extreme progression of symptoms, clear clinical, imaging and electrophysiological evidence of a lesion, and a failure of conservative treatment. As per the documentation submitted, there was no evidence of radiculopathy upon physical examination. The physician noted intact motor and sensory function to bilateral lower extremities with only a decrease in sensation to the lateral thighs bilaterally. There were no imaging studies or electrodiagnostic reports submitted for review. There is no evidence of documented instability on flexion and extension view radiographs. There has not been a psychological evaluation prior to the requested surgical intervention. Additionally, there is no evidence of an exhaustion of conservative treatment. The request for posterior segmental instrumentation is not medically necessary or appropriate.

The application of an intervertebral biomechanical device: 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 Physician Reviewer's decision rationale: The Low Back Complaints Chapter of the ACOEM Practice Guidelines state referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation due to radiating pain for more than one month, extreme progression of symptoms, clear clinical, imaging and electrophysiological evidence of a lesion, and a failure of conservative treatment. As per the documentation submitted, there was no evidence of radiculopathy upon physical examination. The physician noted intact motor and sensory function to bilateral lower extremities with only a decrease in sensation to the lateral thighs bilaterally. There were no

imaging studies or electrodiagnostic reports submitted for review. There is no evidence of documented instability on flexion and extension view radiographs. There has not been a psychological evaluation prior to the requested surgical intervention. Additionally, there is no evidence of an exhaustion of conservative treatment. The request for the application of an intervertebral biomechanical device is not medically necessary or appropriate.

A two-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 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 or appropriate.

Pre-operative labs: 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 or appropriate.

Pre-operative medical clearance: 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 or appropriate.

Cybertech back brace: 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 or appropriate.