

Case Number:	CM13-0058965		
Date Assigned:	12/30/2013	Date of Injury:	06/07/2010
Decision Date:	05/08/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	11/27/2013

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:

The injured worker is a 39-year-old male who reported an injury on 06/07/2010. The mechanism of injury was a fall. The injured worker had an MRI of the lumbar spine on 05/29/2012. At the level of L5-S1, there was a very small 3 mm broad-based left paracentral disc protrusion with an annular fissure without significant spinal canal stenosis. There was a mild left-sided neural foraminal stenosis without significant right-sided neural foraminal stenosis and very mild bilateral facet arthropathy and ligamentum flavum redundancy. There was no high grade spinal canal or neural foraminal stenosis in the lumbar spine. The documentation of 08/12/2013 revealed the injured worker's chief complaint was chronic low back pain. There was a history of a right knee arthroscopic debridement. It was noted the injured worker had failed conservative including physical therapy and lumbar epidural steroid injections which caused adverse reactions. The adverse reaction was noted to be the injured worker was physically sick with fever, chills, headaches, nausea, and vomiting following the injection. Additionally, it was noted the injured worker had a flushing sensation throughout his whole body following the injection. The physical examination revealed a positive leg raise at 45 degrees. There was a positive LasA`gue's sign. There was a motor deficit at L5 distribution on the right side with extensor hallucis longus weakness at 3/5. There was moderate diffuse paraspinal muscle spasm. It was further indicated that the L5 distribution on the right side was intact. The Valsalva maneuver produced significant discomfort. The injured worker's range of motion was limited in all fields and discomfort was noted at terminal end range of motion. There was tenderness to palpation over the midline of L5-S1 as well as over the bilateral lumbar facet joints at L5-S1 and L4-5 levels, right greater than left. The diagnoses included annular tear at L5-S1 and lumbar herniated nucleus pulposus L5-S1. The treatment plan included the injured worker was a candidate for a lumbosacral fusion anteriorly and posteriorly at L5-S1 and that the injured worker would

continue losing weight. The documentation of 11/07/2013 revealed the injured worker would be helped by an interferential unit and a hinged knee brace. The diagnosis was left knee sprain and strain.

IMR ISSUES, DECISIONS AND RATIONALES

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

ANTERIOR INSTRUMENTATION; 2 TO 3 VERTEBRAL SEGMENTS: 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): 307.

Decision rationale: ACOEM Guidelines indicate that there is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back pain in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability in motion in the segment operated on. It is recommended that the injured worker undergo a psychological evaluation prior to surgery. The clinical documentation submitted for review failed to indicate the injured worker had previously undergone a surgical decompression, had a spinal fracture, dislocation, or spondylolisthesis, and that there was instability in motion in the requested segment. The MRI of 05/29/2012 failed to provide instability. There was lack of documentation including x-rays on extension and flexion to indicate the injured worker had instability. Per the physician, it was indicated that the injured worker should have a lumbar fusion since they were not a candidate for additional injection therapy. There was a lack of bilateral radicular findings. There was no documentation of a psychological examination. Given the above, the request for anterior instrumentation, 2 to 3 vertebral segments is not medically necessary.

APPLICATION OF INTERVERTEBRAL BIOCHANICAL DEVICE: 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): 307.

Decision rationale: ACOEM Guidelines indicate that there is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back pain in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability in motion in the segment operated on. It is recommended

that the injured worker undergo a psychological evaluation prior to surgery. The clinical documentation submitted for review failed to indicate the injured worker had previously undergone a surgical decompression, had a spinal fracture, dislocation, or spondylolisthesis, and that there was instability in motion in the requested segment. The MRI of 05/29/2012 failed to provide instability. There was lack of documentation including x-rays on extension and flexion to indicate the injured worker had instability. Per the physician, it was indicated that the injured worker should have a lumbar fusion since they were not a candidate for additional injection therapy. There was a lack of bilateral radicular findings. There was no documentation of a psychological examination. Given the above, the request for anterior instrumentation, 2 to 3 vertebral segments is not medically necessary.

VERTRAL CORPECTOMY, COMBINED THORACOLUMBAR APPROACH: 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): 307.

Decision rationale: ACOEM Guidelines indicate that there is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back pain in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability in motion in the segment operated on. It is recommended that the injured worker undergo a psychological evaluation prior to surgery. The clinical documentation submitted for review failed to indicate the injured worker had previously undergone a surgical decompression, had a spinal fracture, dislocation, or spondylolisthesis, and that there was instability in motion in the requested segment. The MRI of 05/29/2012 failed to provide instability. There was lack of documentation including x-rays on extension and flexion to indicate the injured worker had instability. Per the physician, it was indicated that the injured worker should have a lumbar fusion since they were not a candidate for additional injection therapy. There was a lack of bilateral radicular findings. There was no documentation of a psychological examination. Given the above, the request for anterior instrumentation, 2 to 3 vertebral segments is not medically necessary.

VERTRAL CORPECTOMY, PARTIAL OR COMPLETE, COMBINED THORACOLUMBAR APPROACH: 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): 307.

Decision rationale: ACOEM Guidelines indicate that there is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back pain in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability in motion in the segment operated on. It is recommended that the injured worker undergo a psychological evaluation prior to surgery. The clinical documentation submitted for review failed to indicate the injured worker had previously undergone a surgical decompression, had a spinal fracture, dislocation, or spondylolisthesis, and that there was instability in motion in the requested segment. The MRI of 05/29/2012 failed to provide instability. There was lack of documentation including x-rays on extension and flexion to indicate the injured worker had instability. Per the physician, it was indicated that the injured worker should have a lumbar fusion since they were not a candidate for additional injection therapy. There was a lack of bilateral radicular findings. There was no documentation of a psychological examination. Given the above, the request for anterior instrumentation, 2 to 3 vertebral segments is not medically necessary.

ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (QTY: 2): 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): 306-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Discectomy.

Decision rationale: ACOEM Guidelines indicate that there is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back pain in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability in motion in the segment operated on. It is recommended that the injured worker undergo a psychological evaluation prior to surgery. ACOEM guidelines address a discectomy, however, do not address specific criteria for a discectomy. As such, secondary guidelines were sought. Official Disability Guidelines indicate that the patient should have subjective symptoms and objective findings upon examination to confirm the presence of radiculopathy. These findings include straight leg raising test, crossed straight leg raise and reflex exams that correlate with symptoms and imaging. They must have documentation of failed conservative care. The documentation indicated that the injured worker had a motor deficit at L5 on the right with right extensor hallucis weakness rated a 3/5. The imaging failed to indicate nerve impingement. It was indicated the injured worker underwent an epidural steroid injection, and had a reaction to the injection. However, there was lack of documentation of other conservative care. The discectomy would not be supported. Given the above, the request for an arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace quantity 2, is not medically necessary>>

ALLOGRAFT, STRUCTURAL, FOR SPINE SURGERY: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Allograft.

Decision rationale: Official Disability Guidelines do not recommend transplantation of intervertebral discs until further research is completed. Given the above, the request for allograft structural for spine surgery is not medically necessary.

AUTOGRAFT, FOR SPINE SURGERY (INCLUDES HARVESTING THE GRAFT) AND AUTOGRAFT, MORSELIZED, WITH PLACEMENT OF OSTEOPROMOTIVE MATERIAL: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Iliac crest donor-site pain treatment, autograft.

Decision rationale: Official Disability Guidelines indicate that autograft is considered the gold standard in spine fusion procedures in comparison with allograft because it is highly osteo-conductive, osteo-inductive, and avoids the risk of disease transmission, and is immunogenic and compatible to the host bone. However since the surgical procedure is not being certified, the request for autograft for spine surgery is not medically necessary.

POSTERIOR SEGMENTAL AND NONSEGMENTAL INSTRUMENTATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 307.

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

Decision rationale: ACOEM Guidelines indicate that there is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back pain in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability in motion in the segment operated on. It is recommended that the injured worker undergo a psychological evaluation prior to surgery. As with above procedures, the clinical documentation did not show that the criteria were met. Therefore, the request is not medically necessary.

ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, INCLUDING LAMINECTOMY (QTY:2): 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): 306-307.

Decision rationale: ACOEM indicate that direct methods of nerve root decompression include laminotomy, standard discectomy, and laminectomy, and that a laminectomy is performed for spinal stenosis. The MRI indicated that the injured worker had no high grade spinal canal stenosis. The laminectomy would not be supported. Given the above, the request for arthrodesis, posterior interbody technique, including laminectomy quantity 2 is not medically necessary.

LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Laminectomy/laminotomy.

Decision rationale: Per Official Disability Guidelines a laminectomy is performed for spinal stenosis. The clinical documentation submitted for review indicated the injured worker had very mild left-sided neural foraminal stenosis without significant right-sided neural foraminal stenosis and there was no high grade spinal canal stenosis per the MRI. The laminectomy would not be supported. There was no documentation indicating the rationale for a laminectomy, facetectomy and foraminotomy. Given the above, the request for a laminectomy, facetectomy, and foraminotomy quantity 2 is not medically necessary.

ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL (QTY:2): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Laminectomy/laminotomy.

Decision rationale: Per Official Disability Guidelines a laminectomy is performed for spinal stenosis. The clinical documentation submitted for review indicated the injured worker had very mild left-sided neural foraminal stenosis without significant right-sided neural foraminal stenosis and there was no high grade spinal canal stenosis per the MRI. The laminectomy would not be supported. There was no documentation indicating the rationale for a laminectomy, facetectomy

and foraminotomy. Given the above, the request for a laminectomy, facetectomy, and foraminotomy quantity 2 is not medically necessary.

A 3-IN-1 COMMODE: 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 items/services are medically necessary.

A LUMBAR SACRAL ORTHOSIS: 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 items/services are medically necessary.

AN OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, SPINAL APPLICATIONS: 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 items/services are medically necessary.

A PNEUMATIC COMPRESSOR; NON-SEGMENTAL HOME MODEL: 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 items/services are medically necessary.