MAXIMUS Federal Services

Case Number:	CM14-0004071		
Date Assigned:	01/31/2014	Date of Injury:	07/28/2005
Decision Date:	06/20/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/09/2014

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, 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:

This is a 58-year-old female patient who was injured on 7/28/05 when she slipped and fell off a step stool. A 12/5/13 progress report indicates that the patient had not obtained any relief with a spinal cord stimulator. She continues to have severe dysfunction and pain in the back and severe leg radiculopathies. Pain affects her activities of daily living and her ambulatory abilities. Physical exam demonstrates lumbar tenderness, lumbar spasm, limited lumbar range of motion, positive straight leg raise test, difficulty performing heel and toe walk. A 5/31/13 lumbar contrast CT demonstrates, at L3-4, mild disk space narrowing, anterior osteophytosis, a 3-4 mm diffuse disk bulge, mild narrowing of the spinal canal, mild to moderate narrowing of the lateral recesses at the level of the disk space and mild to moderate bilateral neural foraminal narrowing. There is no evidence of neural foraminal narrowing at L4-5 or L5-S1. There is posterior instrumentation and bilateral posterior bony fusion from L4 through S1. The patient underwent L4-5 and L5-S1 posterior fusion in 2007. The patient has also had aquatic therapy, physical therapy, medication, acupuncture, chiropractic care, lumbar ESI, and activity modification. Spinal cord stimulator was placed in 2012. There is documentation of a previous 1/2/14 adverse determination for lack of formal imaging studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

POSTERIOR SPINAL FUSION AND DECOMPRESSION AT L3-4 WITH INCORPORATION INTO THE HARDWARE AT L4-L5 AND L5-S1, BILATERAL

REVISION LAMINONOTOMY FORAMINOTOMY AND RESECTION OF BONEY HYPEROSTOSIS AT THE BILATERAL L4-L5 AND L5-S1 LEVELS.: 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 based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACH CHAPTER, DECOMPRESSION AND FUSION OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: AMA GUIDES (RADICULOPATHY, INSTABILITY)

Decision rationale: The ACOEM Guidelines states that surgical intervention is recommended for patients who have 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; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair; and failure of conservative treatment. In addition, ACOEM Guidelines states that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. While it is acknowledged that the patient patient presents with a protracted and complex case history including previous L4-S1 decompression and fusion and recalcitrant back pain, there remains no imaging evidence of functional spinal unit failure, degenerative spondylolisthesis, or dynamic instability to warrant a fusion procedure at L3-4. A psychological clearance was not obtained. Imaging reports are also negative for frank nerve root compromise at L4-5 and L5-S1 that would warrant revision laminotomy and foraminotomy at these levels. Flexion/extension views to corroborate the integrity of the L3-4 segment were not obtained. Therefore, the request is not medically necessary and appropriate.