MAXIMUS Federal Services

Case Number:	CM14-0005941		
Date Assigned:	02/05/2014	Date of Injury:	12/07/2009
Decision Date:	06/23/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/13/2014

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, 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:

A 2/6/14 progress report indicates severe difficulty sleeping secondary to pain and increased lumbar pain with movement. Physical exam demonstrates positive straight leg raise test bilaterally and diminished reflexes in both feet. On 10/28/13, the patient's height was 75-inch and weight was 322 pounds. the patient can hardly move. A 7/17/13 AME report indicates that the patient is a good candidate for pain management and consideration for lumbar epidural steroid injections. 8/25/10 lumbar MRI demonstrates, at L4-5, postsurgical changes following right hemilaminotomy, bilateral facet disease, and a mild broad-based disk bulge eccentric to the right resulting in moderate to severe right foraminal narrowing and probable impingement upon the exiting right L4 nerve root with moderate left foraminal narrowing. Treatment to date has included TENS unit, aqua therapy, ankle supports, lumbar ESI, and medication. The patient underwent previous L4-5 laminectomy. The requested surgery was requested and denied several times over the past years.

IMR ISSUES, DECISIONS AND RATIONALES

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

ANTERIOR LUMBAR INTERBODY FUSION BY DIRECT LATELY APPROACH AT L4-5 WITH BONE GRAFT SUBSTITUTE AND POSTERIOR PERCUTANEOUS PEDICLE SCREW FIXATION AT L4-5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, 305, 307, 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 Chapter, Decompression/Fusion X Other Medical Treatment Guideline or Medical Evidence: AMA Guides (Radiculopathy, Instability).

Decision rationale: CA MTUS 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, CA MTUS 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. The patient presents with a protracted case history, but an ambiguous clinical case. While there are significant and dominant functional limitations, the patient presents with co-morbidities including morbid obesity and diabetes. The patient reportedly fared poorly with previous lumbar hemilamenicetomy at L4-5. A psychological clearance for the proposed fusion procedure was not obtained. The patient does not meet fusion criteria; imaging reports did not corroborate degenerative spondylolisthesis, dynamic instability, or functional spinal unit failure. Therefore, the request for ANTERIOR LUMBAR INTERBODY FUSION BY DIRECT LATERAL APPROACH AT L4-5 WITH BONE GRAFT SUBSTITUTE AND POSTERIOR PERCUTANEOUS PEDICLE SCREW FIXATION AT L4-5 was not medically necessary.

PRE-OP 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: The dependent request for ANTERIOR LUMBAR INTERBODY FUSION BY DIRECT LATERAL APPROACH AT L4-5 WITH BONE GRAFT SUBSTITUTE AND POSTERIOR PERCUTANEOUS PEDICLE SCREW FIXATION AT L4-5 was deemed not medically necessary. Therefore, the request for PRE-OP CLEARANCE was also not medically necessary.

MRI OF THE LUMBAR SPINE W/WITHOUT CONTRAST: 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: The dependent request for ANTERIOR LUMBAR INTERBODY FUSION BY DIRECT LATERAL APPROACH AT L4-5 WITH BONE GRAFT SUBSTITUTE AND POSTERIOR PERCUTANEOUS PEDICLE SCREW FIXATION AT L4-5 was deemed not medically necessary. Therefore, the request for MRI OF THE LUMBAR SPINE W/WITHOUT CONTRAST was also not medically necessary.

CT SCAN LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, 303-304.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The dependent request for ANTERIOR LUMBAR INTERBODY FUSION BY DIRECT LATERAL APPROACH AT L4-5 WITH BONE GRAFT SUBSTITUTE AND POSTERIOR PERCUTANEOUS PEDICLE SCREW FIXATION AT L4-5 was deemed not medically necessary. Therefore, the request for CT SCAN LUMBAR SPINE was also not medically necessary.