MAXIMUS Federal Services

Case Number:	CM14-0103365		
Date Assigned:	07/30/2014	Date of Injury:	07/10/1988
Decision Date:	08/29/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	07/03/2014

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 58-year-old female senior utility clerk sustained an industrial injury on 7/10/88, due to repetitive heavy lifting. Past medical history was positive for fibromyalgia, rheumatoid arthritis, depression, insomnia, sleep apnea, asthma, anemia, gastroesophageal reflux disease, hypertension, migraines, urinary incontinence, and obesity (body mass index 40.16). Past surgical history was positive for L4-S1 decompression, fusion and instrumentation in 1992. The patient underwent bilateral L2/3 and L3/4 intraarticular facet injections on 5/14/13 and L3 bilateral transforaminal epidural steroid injections on 7/12/13. The 12/11/13 lumbar spine CT myelogram impression documented prior L4-S1 fusion, degenerative disc space narrowing and spondylosis at L2/3 with evidence of fairly severe canal stenosis. There was significant canal narrowing at L3/4, small ventral defect at L1/2, and grade 1 anterolisthesis at L3/4 with no definite abnormal movement between the flexion and extension views. There was mildly increased anterolisthesis on the upright views compared to the prone cross table view. The 4/15/14 treating physician report cited constant grade 7/10 low back pain with left anterior and posterior thigh pain, paresthesias and numbness. She reported left hip weakness and the left leg giving out. Symptoms were worse with walking or prolonged sitting. Leg symptoms had been reported for one year. Back symptoms had worsened over the past year. Symptoms were improved with heat, medications, ice, and rest. The patient had undergone two injections that helped her for 3 months. Physical exam documented the patient was able to heel/toe walk well, tandem gait was intact, and there was no spinal tenderness. Lumbar range of motion testing documented forward flexion 40, extension 5, and bilateral lateral flexion 5 degrees. Lower extremity sensation, motor function and reflexes were normal. Straight leg raise, Faber's, and internal/external rotation testing were negative. The diagnosis was severe central stenosis L2-L4, moderate stenosis L1/2, degenerative spinal listhesis at L3/4, and prior L4-S1 decompression and

fusion with instrumentation. The treatment plan recommended definitive surgical management. The patient had not worked since October 2013 due to rheumatoid arthritis affecting her fingers, wrists, shoulders, knees, ankles, feet, and hips. The 6/4/14 utilization review denied the request for lumbar decompression and fusion as psychosocial evaluation was not evidenced.

IMR ISSUES, DECISIONS AND RATIONALES

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

L1-4 Decompression , L3-4 Fusion , L3-S1 Instrumentation , L4-S1 instrumentation Removal Allograft, Fluroscopy with Surgical Assistant Treatment: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) http://www.ncbi.nlm.nih.gov/pubmed/10766062, Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The ACOEM Revised Low Back Disorder guidelines recommend decompression surgery as an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management. Lumbar discectomy is recommended for patients with radiculopathy due to on-going nerve root compression who continue to have significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability has been proven. The Official Disability Guidelines recommend criteria for lumbar discectomy and laminectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Fusion may be supported for surgically induced segmental instability but pre-operative guidelines recommend completion of all physical medicine and manual therapy interventions and psychosocial screen with all confounding issues addressed. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been fully tried and failed. There is no definite evidence of spinal segmental instability on flexion/extension imaging. There is a history of depression with no evidence of a psychosocial evaluation. Therefore, this request for L1-4 decompression, L3-4 fusion, L3-S1 instrumentation, L4-S1 instrumentation, removal allograft, fluoroscopy with surgical assistant treatment is not medically necessary.

Preoperative Labs: CMP, CBC, PT/ PTT, CXR, EKG: 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.

Medical Clearance consult: 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.

LS Corset 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.