MAXIMUS Federal Services

Case Number:	CM14-0119744		
Date Assigned:	08/06/2014	Date of Injury:	04/20/2011
Decision Date:	09/10/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	07/28/2014

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 bonding aircraft assembler sustained an industrial injury on 4/20/11. The mechanism of injury was not documented. Spine surgeon review of the 5/23/13 lumbar MRI documented 3 mm right lateral disc protrusion at L4/5 with evidence of disc desiccation, and minor spondylosis with right annular fissure tear. There was also evidence of right lateral inferior L4 end plate with Modic II signal alteration. The 12/11/13 AME report cited lumbar spine pain radiating down to the anterolateral aspect of the right leg to the dorsal surface of the right foot with a feeling of weakness. Pain was aggravated by bending, lifting, twisting, pushing, pulling, sitting, and walking multiple blocks. The lumbar spine exam documented midline, right posterior superior iliac spine and right sacroiliac joint tenderness. Motor function and reflexes were within normal limits. There was diminished sensation to the anterolateral aspect of the right leg to the dorsal surface of the right foot. Mechanical and nerve tension signs were negative. Lower extremity girth measurements were symmetrical. The AME discussed cervical spine surgical indications for fusion and recommended treatment of the cervical spine before the lumbar spine. He stated that in the future the patient may also be a candidate for an arthrodesis of the lumbar spine. The 12/12/13 lower extremity electrodiagnostic study impression documented a normal nerve conduction study. An abnormal EMG was reported with right chronic L5 denervation with no other evidence of active lumbar radiculopathy in the bilateral lower extremities. The 6/16/14 treating physician report cited significant cervical spine pain, left upper extremity pain, lumbar spine pain and right lower extremity pain. She was working very light transitional duty at her job. Lumbar spine exam documented stiffness, spasms, radiculopathy to the right lower extremity, positive straight leg raise, and decreased range of motion. The patient had failed all conservative measures including physical therapy, pain medication, activity modification, and epidural injections. The spine surgeon had recommended surgery and the AME recommended

physical therapy and medication. AME reevaluation in December 2013 agreed with the surgical plan per MTUS guidelines. Cervical spine surgery had been recommended for C5 radiculopathy but had been denied. Lumbar spine surgery was requested per the spine surgeon, along with follow-up evaluation for surgical planning and treatment. The 7/14/14 utilization review denied the request for lumbar spine surgery and treatment with the spine surgeon as there were no objective findings of L5 nerve involvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar 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): 202-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Fusion (spinal).

Decision rationale: The ACOEM Revised Low Back Disorder guidelines recommend lumbar decompression surgery 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. Guideline indications include radicular pain syndrome with current dermatomal pain and/or numbness, or myotomal muscle weakness all consistent with a herniated disc. Imaging findings are required that confirm persisting nerve root compression at the level and on the side predicted by the history and clinical examination. Lumbar fusion is not recommended unless concomitant instability has been proven. The Official Disability Guidelines state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. The specific procedure and levels for lumbar spine surgery are not documented, but arthrodesis was indicated by the AME. There is no evidence of acute or progressive neurologic dysfunction. There is no radiographic or imaging evidence of segmental instability. A psychosocial clearance is not evident. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this request for lumbar spine surgery is not medically necessary.

[redacted] Evaluation & Treatment and follow up with [redacted]: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127.

Decision rationale: The California MTUS guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. The medical necessity of surgical treatment has not been established at this time. While evaluation may be indicated following completion of all pre-operative clinical surgical indications, treatment at the time is not supported by guidelines. Therefore, the request for evaluation, treatment and follow-up with the spine surgeon is not medically necessary.