MAXIMUS Federal Services

Case Number:	CM14-0124797		
Date Assigned:	08/08/2014	Date of Injury:	07/16/2009
Decision Date:	09/11/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/07/2014

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:

The records presented for review indicate that the 59-year-old female was injured on July 16, 2009. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated July 7, 2014, indicates that there are ongoing complaints of low back pain radiating to the right lower extremity with numbness and weakness. There were also complaints of neck pain radiating to the right arm. Current medications include Nexium and Norco. The physical examination demonstrated tenderness of the cervical spine and decreased cervical spine range of motion. There was also decreased lumbar spine range of motion and tenderness over the lumbar spinous processes and the right side paraspinal muscles. There was also tenderness at the right and left sacroiliac joints. There was a positive straight leg raise test at 75 bilaterally and a normal lower extremity neurological examination. Diagnostic imaging studies were not reviewed during this visit. Previous treatment includes cervical spine surgery. A request had been made for a posterior interbody fusion utilizing right iliac crest bone graft, a fusion of L3 - L4, L4 - L5, and L5 - S1 as well as a laminectomy at L3 - L4 with disc excision at L3 - L4 and L4 - L5 and was not certified in the pre-authorization process on July 17, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior inter-body infusion withcages utilizing right lilac crest bone graft: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official disabilities guidelines.

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

Decision rationale: The ACOEM practice guidelines do not support a spinal fusion in the absence of fracture, dislocation, spondylisthesis, instability or evidence of tumor/infection. Review of the available medical records document a diagnosis of lumbar radiculopathy, but fail to demonstrate any of the criteria for a lumbar fusion. Furthermore, there are no flexion/extension plain radiographs of the lumbar spine demonstrating instability, and no documentation of lumbar epidural steroid injections. Given the lack of documentation, the request for a posterior interbody fusion with cages utilizing right-sided iliac crest bone graft is not medically necessary.

Bilateral lateral fusion at L3-4 and L4-5 plus possible L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official disabilities guidelines.

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

Decision rationale: The ACOEM practice guidelines do not support a spinal fusion in the absence of fracture, dislocation, spondylisthesis, instability or evidence of tumor/infection. Review of the available medical records document a diagnosis of lumbar radiculopathy, but fail to demonstrate any of the criteria for a lumbar fusion. Furthermore, there are no flexion/extension plain radiographs of the lumbar spine demonstrating instability, and no documentation of lumbar epidural steroid injections. Given the lack of documentation, the request for a bilateral lateral fusion at L3 - L4 and L4 - L5 plus a possible fusion at L5 - S1 is not medically necessary.

Urgent lumbar laminectomy at L3-L4 with disc excision at L3-4 and L4-5 plus: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official disabilities guidelines.

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

Decision rationale: The ACOEM practice guidelines support a lumbar laminectomy/discectomy for the treatment of sub-acute and chronic radiculopathy due to ongoing nerve root compression who continue to have significant pain and functional limitation after 6 weeks of conservative treatment. Review of the available medical records, documents a diagnosis of chronic lumbar radiculopathy with failure to conservative treatment. As such, this request for a lumbar laminectomy at L3 - L4 with disc excision at L3 - L4 and L4 - L5 is not medically necessary.