

Case Number:	CM14-0126311		
Date Assigned:	08/13/2014	Date of Injury:	06/15/2009
Decision Date:	12/11/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/08/2014

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:

According to the records made available for review, this is a 35-year-old female with a 6/15/09 date of injury. At the time (7/29/14) of the Decision for Anterior lumbar stabilization and decompression at L5- S1, Assistant Surgeon, Inpatient stay x 1-3 days, and TLSO Brace, there is documentation of subjective (low back pain radiating to groin as well as lower extremities with numbness and tingling) and objective (limited lumbar range of motion, positive bilateral straight leg raise, and decreased sensory exam over S1 dermatome) findings, imaging findings (MRI lumbar spine (6/4/14) report revealed moderate diffuse disc herniation at L5-S1 that causes moderate stenosis of spinal canal and stenosis of left lateral recess with contact on left S1 transiting nerve root), current diagnoses (lumbar spine sprain/strain, lumbar intervertebral disc displacement, and lumbar neuritis/radiculitis), and treatment to date (physical therapy, lumbar epidural injection, and medications). Medical report identifies one-half- a grade of instability as a rationale for the requested fusion. Regarding Anterior lumbar stabilization and decompression at L5- S, there is no documentation of subjective findings which confirms presence of radiculopathy; and an indication for fusion (instability (imaging demonstrating 4.5 mm or greater movement).

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior lumbar stabilization and decompression at L5- S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary last updated 7/3/14

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, Discectomy/laminectomy

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; and activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, failure of conservative treatment; and an indication for fusion (instability (imaging demonstrating 4.5 mm or greater movement) or a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminotomy/fusion. ODG identifies documentation of Symptoms/Findings (pain, numbness or tingling in a nerve root distribution) which confirm presence of radiculopathy, objective findings (sensory changes, motor changes, or reflex changes (if reflex present)) that correlate with symptoms, and imaging findings (nerve root compression or moderate or greater central canal, lateral recess, or neural foraminal stenosis) in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression. Within the medical information available for review, there is documentation of diagnoses of lumbar spine sprain/strain, lumbar intervertebral disc displacement, and lumbar neuritis/radiculitis. In addition, given documentation of objective (decreased sensory exam over S1 dermatome) and imaging (MRI of lumbar spine identifying moderate diffuse disc herniation at L5-S1 that causes moderate stenosis of spinal canal and stenosis of left lateral recess with contact on left S1 transiting nerve root) findings, there is documentation of imaging studies (moderate stenosis of spinal canal and lateral recess) with accompanying objective (sensory changes) signs of neural compromise exam findings. In addition, there is documentation of failure of conservative treatment. However, despite nonspecific documentation of subjective (low back pain radiating to groin as well as lower extremities with numbness and tingling) findings, there is no specific (to a nerve root distribution) documentation of subjective findings which confirms presence of radiculopathy. In addition, despite documentation one-half- a grade of instability as a rationale for request for fusion, there is no documentation of an indication for fusion (instability (imaging demonstrating 4.5 mm or greater movement)). Therefore, based on guidelines and a review of the evidence, the request for Anterior lumbar stabilization and decompression at L5- S1 is not medically necessary.

Assistant Surgeon: 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.

Inpatient stay x 1-3 days: 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.

TLSO 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.