

Case Number:	CM14-0150376		
Date Assigned:	09/18/2014	Date of Injury:	03/16/2012
Decision Date:	10/17/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	09/16/2014

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 Neurological 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 50-year-old male with a 3/16/12 date of injury, and L5-S1 discectomy, facetectomy, foraminotomy, and decompression on 12/17/13. At the time (8/15/14) of the Decision for Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy L5-S1 QTY: 1, Arthrodesis, posterior or posterolateral technique, single level; L5-S1 QTY: 1, Posterior Non-Segmental Instrumentation (Eg. Harrington Rod Technique, Pedicle Fixation L5-S1 QTY: 1, Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) QTY: 1, Nerve microdissection and microrepair QTY: 1, and Exploration of spinal fusion L5-S1 QTY: 1, there is documentation of subjective (persistent back pain radiating to the lower extremities, buttocks, thighs, and calves) and objective (4/5 right dorsiflexion and plantar flexion, tenderness over the lumbar area, decrease lumbar range of motion with pain, diminished light touch to the anterior shin and bottom of the left foot, and absent right ankle reflex) findings, imaging findings (reported MRI of the lumbar spine (7/10/14) revealed L4-L5 demonstrates facet degenerative changes, mild to moderate narrowing of the right lateral recess and moderate to severe right neural foraminal narrowing along with moderate left foraminal narrowing, and a 2mm posterior disc bulge; report not available for review)), current diagnoses (lumbar stenosis and lumbar disc displacement), and treatment to date (medications and physical therapy). Regarding Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy L5-S1, there is no documentation of imaging findings in concordance between radicular findings and physical exam findings (S1); and an indication for fusion (instability or a statement that decompression will create surgically induced instability).

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy L5-S1 QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307. Decision based on Non-MTUS Citation ACOEM Guidelines, 2nd Edition, 2004 (p.307).ODG (Official Disability Guidelines); Integrated Treatment/Disability Duration Guidelines; Low Back-Lumbar & Thoracic (Acute & Chronic)

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 and Fusion (spinal)

Decision rationale: MTUS reference to ACOEM 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; 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 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 which confirm presence of radiculopathy, objective findings that correlate with symptoms and imaging findings in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression/laminotomy. In addition, ODG identifies documentation of spinal instability (lumbar inter-segmental movement of more than 4.5 mm) as criteria necessary to support the medical necessity of fusion. Within the medical information available for review, there is documentation of diagnoses of lumbar stenosis and lumbar disc displacement. In addition, there is documentation of subjective (persistent back pain radiating to the lower extremities, buttocks, thighs, and calves (S1)) findings which confirms presence of radiculopathy. Furthermore, there is documentation of objective (4/5 right dorsiflexion and plantar flexion and absent right ankle reflex (S1)) findings that correlate with symptoms. However, despite documentation of an imaging findings of L4-L5 demonstrates facet degenerative changes, mild to moderate narrowing of the right lateral recess and moderate to severe right neural foraminal narrowing along with moderate left foraminal narrowing, and a 2mm posterior disc bulge, there is no documentation of imaging findings in concordance between radicular findings and physical exam findings (S1). In addition, there is no documentation of an indication for fusion (instability or a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy L5-S1 QTY: 1 is not medically necessary.

Arthrodesis, posterior or posterolateral technique, single level; L5-S1 QTY: 1: 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 med necessary, none of the associated services are medically necessary.

Posterior Non-Segmental Instrumentation (Eg. Harrington Rod Technique, Pedicle Fixation L5-S1 QTY: 1: 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 med necessary, none of the associated services are medically necessary.

Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) QTY: 1: 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 med necessary, none of the associated services are medically necessary.

Nerve microdissection and microrepair QTY: 1: 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 (Official Disability Guidelines); Integrated Treatment/Disability Duration Guidelines; Low Back-Lumbar & Thoracic (Acute & Chronic)

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

Decision rationale: There is no documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for Nerve microdissection and microrepair QTY: 1 is not medically necessary.

Exploration of spinal fusion L5-S1 QTY: 1: 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 med necessary, none of the associated services are medically necessary.