

Case Number:	CM14-0170565		
Date Assigned:	10/20/2014	Date of Injury:	09/05/2010
Decision Date:	11/20/2014	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	10/15/2014

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 Orthopaedic 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 42-year-old female sustained an industrial injury on 9/5/10. The mechanism of injury was not documented. The 6/27/12 electrodiagnostic study demonstrated evidence of chronic right L5 S1 lumbar radiculopathy. Records documented a lumbar spine MRI in September 2013 showed significant disc space collapse at L4/5 with resultant bilateral foraminal stenosis. There was a right paracentral disc herniation with moderate right L5 lateral recess stenosis and compression of the L5 nerve root. There was no significant neurologic compromised at the other levels. Records indicated a gradual evolution of depression relative to chronic pain syndrome and prior recommendations for psychiatric/psychological evaluation for medication management and cognitive behavioral counseling. The 9/22/14 spinal surgeon report cited persistent low back pain radiating to lower extremities with L5 burning dysesthesias, right greater than left. Symptoms were progressively worsening. Current medications included Celebrex and Norco. Conservative treatment to date had included physical therapy, 3 epidural injections, and medication management without relief in her symptoms. Physical exam documented stable, steady gait with midline distal lumbar tenderness, worsened with extension-based maneuvers. There was burning dysesthesias in an L5 distribution, right greater than left. There was right extensor hallucis longus 4+/5 weakness. There was a markedly positive right straight leg raise. X-rays showed severe L4/5 disc degeneration. The diagnosis was L4/5 disc degeneration with foraminal stenosis and L4/5 disc herniation impinging upon the descending right L5 nerve root, with right lower extremity radiculopathy, recalcitrant to conservative treatment. The treatment plan recommended L4/5 anterior lumbar interbody fusion. The 10/3/14 utilization review denied the lumbar spine surgery and associated requests as there was limited imaging evidence that supports any instability at the L5/S1 which would support fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior lumbar interbody fusion L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary last updated 08/22/2014; regarding: Indications for spinal fusion / criteria for spinal fusion / Indications for Surgery - Discectomy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Fusion (spinal)

Decision rationale: The ACOEM revised low back guidelines state that lumbar fusion is not recommended as a treatment for patients with radiculopathy from disc herniation. The Official Disability Guidelines (ODG) 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. There is no radiographic or imaging evidence of segmental instability. Psychosocial screening is not evidenced. Therefore, this request is not medically necessary.

x3 days inpatient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Hospital length of stay (LOS)

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Surgical consult with vascular co-surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Centers for Medicare and Medicaid services, Physician Fee Schedule

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Internist for medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Labs: CBC, UA, PTT, PT/INR, nares culture for MRSA: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Low profile lumbar spine spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 138-139. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

