

Case Number:	CM14-0170966		
Date Assigned:	10/30/2014	Date of Injury:	04/06/2011
Decision Date:	12/16/2014	UR Denial Date:	10/06/2014
Priority:	Standard	Application Received:	10/16/2014

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 Orthopedic Surgeon 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 32-year-old male with a 4/6/11 date of injury. At the time (9/24/14) of request for authorization for L5-S1 Anterior lumbar interbody fusion, Inpatient stay 2 days, Intraoperative neurophysiological monitoring during L5-S1 Anterior lumbar interbody fusion, Approach surgeon for anterior approach for L5-S1 ALIF/PFWI, Pre-op labs: CMP, CBC, PT, PTT, UA), DME: lumbar brace, Bone growth stimulator, Vascutherm cold therapy unit, Home health RN evaluation post-surgery, and Post-operative physical therapy (may include aquatic therapy) 2 x 6, there is documentation of subjective (low back pain radiating to right greater than left leg towards the heel and outside of the foot) and objective (tenderness over the L5-S1 area, decreased range of motion, positive right straight leg raising test, hyperreflexia right deep tendon reflexes, diminished sensation over right heel and outside of foot, normal motor strength) findings, imaging findings (flexion and extension X-ray of the lumbar spine (8/19/13) report revealed negative radiographic examination of the lumbar spine and MRI of the lumbar spine (7/24/14) report revealed central and right paracentral disc herniation and partially extruded disc at L5-S1 seen displacing the right S1 and S2 nerve), current diagnoses (displacement of lumbar intervertebral disc without myelopathy), and treatment to date (medications, home exercise program, epidural steroid injection, activity modification, and physical therapy). Regarding anterior lumbar interbody fusion, there is no documentation of 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:

L5-S1 Anterior lumbar interbody fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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 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 (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 a diagnosis of displacement of lumbar intervertebral disc without myelopathy. In addition, there is documentation of failure of conservative treatment (medications, home exercise program, epidural steroid injection, activity modification, and physical therapy). Furthermore, given documentation of subjective (low back pain radiating to right greater than left leg towards the heel and outside of the foot) and objective (hyporeflexic right deep tendon reflexes and diminished sensation over right heel and outside of foot) findings, there is documentation of severe and disabling lower leg symptoms (subjective and objective sign of radiculopathy (S1)). Lastly, given documentation of imaging findings (MRI of the lumbar spine identifying right paracentral disc herniation and partially extruded disc at L5-S1 seen displacing the right S1 nerve), there is documentation of imaging findings (nerve root compression) in concordance with radicular findings on physical exam findings. However, given documentation of imaging findings (Flexion and extension X-ray of the lumbar spine identifying negative radiographic examination of the lumbar spine), 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 L5-S1 Anterior lumbar interbody fusion is not medically necessary.

Associated Surgical Service: Inpatient stay 2 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.

Associated Surgical Service: Intraoperative neurophysiological monitoring during L5-S1 Anterior lumbar interbody fusion: 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.

Associated Surgical Service: Approach surgeon for anterior approach for L5-S1 ALIF/PFWI: 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.

Associated Surgical Services: Pre-op labs: CMP, CBC, PT, PTT, UA): 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.

Associated Surgical Service: DME: lumbar 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.

Associated Surgical Service: one growth stimulator: 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.

Associated Surgical Service: Vascutherm cold therapy unit: 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.

Associated Surgical Service: Home health RN evaluation post surgery: 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.

Associated Surgical Service: Post-operative physical therapy (may include aquatic therapy) 2 x 6: 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.