

Case Number:	CM14-0025380		
Date Assigned:	06/11/2014	Date of Injury:	09/29/2010
Decision Date:	09/11/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	02/27/2014

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 patient is a 48-year-old female who has submitted a claim for Industrial Aggravation of L5-S1 Degenerative Disc Disease with Bilateral Foraminal Stenosis and Severe Right Leg Radiculopathy, Industrial Aggravation of L4-5 Degenerative Disc Disease with Severe Right Foraminal Narrowing and Right Leg Radiculopathy and Lateral Listhesis and Collapse on the Right Side with Underlying Degenerative Scoliosis, and Underlying Psychiatric Disease with Possible Bipolar Disorder associated with an industrial injury date of September 29, 2010. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of severe right leg pain and weakness. On physical examination, straight leg raise test was positive. Gait was antalgic. There was severe tenderness over the right buttock area. She had difficulty with heel and toe walking. There was weakness of the left tibialis anterior and extensor hallucis longus, as well as the muscles in the right lower extremity. Lumbar flexion was full. There was tenderness of the right lower lumbar area near the L5-S1 facet joint. Patellar and Achilles reflexes were increased on the right. Sensation was decreased in the dorsal aspect of both feet. MRI without contrast of the lumbar spine dated January 31, 2014 revealed increase in the L4-5 degenerative disc disease and spondylosis resulting in moderate to severe right foraminal stenosis and slight deflection of the right L4 nerve; and severe L5-S1 degenerative disc disease and left foraminal stenosis with borderline left L5 nerve root compression. CT of the lumbar spine dated February 25, 2014 revealed multilevel lower spondylosis with mild central spinal stenosis L4-5 and possible impingement of the exiting right L4 and L5 nerve roots. X-ray of the lumbar spine dated March 17, 2014 revealed collapse at L4-5 and L5-S1 with no evidence of instability. Treatment to date has included medications, cervical spine surgery, trigger point injections, and lumbar epidural steroid injections. Utilization review from February 14, 2014 denied the request for L5-S1 anterior interbody fusion with instrumentation; co-vascular

surgeon; durable medical equipment: lumbar brace and hot/cold therapy unit with wrap; assistant surgeon; preoperative consultation with a vascular surgeon; and possible bilateral posterior laminectomy because the records provided conflicting evidence regarding the presence of radiculopathy findings and a psychiatric clearance was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 ANTERIOR INTERBODY FUSION WITH INSTRUMENTATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back chapter.

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, Fusion (Spinal).

Decision rationale: CA MTUS does not specifically address spinal fusion for chronic low back pain. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that indications for spinal fusion may include: (1) neural arch defect; (2) segmental instability (objectively demonstrable); (3) primary mechanical back pain/functional spinal unit failure/instability; and (4) infection, tumor, or deformity that cause intractable pain, neurological deficit and/or functional disability. Moreover, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate in active rehab pre-op, total disability over six months, active psych diagnosis, and narcotic dependence. In this case, imaging findings revealed segmental collapse. However, recent narrative reports from the requesting provider discuss a treatment plan L4-S1 anterior lumbar interbody fusion. The request, as submitted, would be for just the L5-S1 level. Furthermore, guidelines state that there is a lack of support for fusion for patients with total disability over six months, which the patient has. The patient also has an active psych diagnosis. A progress note dated May 8, 2014 stated that the patient was cleared by her psychiatrist. However, the actual medical note containing the said psychiatric clearance was not included in the records for review. The criteria were not met. Therefore, the request for L5-S1 anterior interbody fusion with instrumentation is not medically necessary.

CO-VASCULAR SURGEON: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics.

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.

DURABLE MEDICAL EQUIPMENT: LUMBAR BRACE AND HOT/COLD THERAPY UNIT WITH WRAP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter, continuous-flow cryotherapy.

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.

ASSISTANT SURGEON: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics.

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.

PREOPERATIVE CONSULTATION WITH A VASCULAR SURGEON: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back chapter.

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.

POSSIBLE BILATERAL POSTERIOR LAMINECTOMY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

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.

