

Case Number:	CM14-0071912		
Date Assigned:	07/16/2014	Date of Injury:	03/14/2006
Decision Date:	08/19/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/19/2014

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 Pennsylvania. 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 claimant is a 49-year-old, female who sustained a vocational lifting injury on 03/14/06 for diagnoses of L4, L5, and S1 disc injury with stenosis, radiculopathy, instability, and back pain. The records provided for review document that at the office visit on 06/12/14 the claimant had right leg pain in the L5 and S1 dermatomal distributions and at the L5-S1 disc resulting in obliteration of the lateral recess at the L4-5 and L5-S1. Examination revealed diminished sensation of the right L5 and S1 dermatomes, muscle atrophy of the right calf, plantar flexion and dorsiflexion were 4/5 on the right. She had an abnormal gait with limping. Ankle jerk reflexes were 0 on the right and 1+ on the left. Knee reflexes were 3+ bilaterally. Straight leg raise was grossly positive on the right after 30 degrees which was limited by severe pain radiating to the foot. The records document that the claimant was seen again in the office on 06/19/14 at which time surgery had been approved for an L4-5 and L5-S1 transforaminal lumbar interbody fusion. The records document that on 07/01/14 the claimant underwent a right-sided L4-5 and L5-S1 complete laminectomy, complete facetectomy, decompression of the thecal sac, nerve roots, discectomy followed by interbody fusion at both levels using cages, autologous bone harvest from the iliac crest followed by posterolateral fusion using pedicle screws. The report of the office visit dated 07/10/14 noted that the claimant was nine days post surgery, ambulating with a walker, and wearing a back brace. The claimant had numbness down her leg into her foot and difficulty sleeping. The office note on 08/03/14 noted that an MRI of the lumbar spine dated 07/26/12 identified 4 to 5 millimeter central disc herniation at L4-5 producing bilateral recess stenosis, facet arthropathy, and loss of disc height with a rather significant lateral recess stenosis. There was similar findings at L5-S1 described as a large extruded disc on the right side practically obliterating the lateral recess where the nerve root of S1 should be located. This

review is to determine the medical necessity of the L4-5 and L5-S1 bilateral laminectomy with medial facetectomy and discectomy followed by fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar 4-5 and Lumbar 5 - Sacral 1 Bilateral Laminectomy with Medial Facetectomy and Discectomy followed by Fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Disorders: E. Spinal Fusion Additional ACOEM, Low Back Complaints, E. Spinal Fusion.

MAXIMUS guideline: Decision based on MTUS ACOEM Practice Guidelines, Chapter 12 Low Back Complaints, pages 305-307 and on the Non-MTUS Official Disability Guidelines (ODG), Low Back Chapter, Fusion Section.

Decision rationale: Based on the California ACOEM Guidelines and supported by the Official Disability Guidelines, the request for Lumbar 4-5 and Lumbar 5 - Sacral 1 Bilateral Laminectomy with Medial Facetectomy and Discectomy followed by Fusion is recommended as medically necessary. ACOEM Guidelines recommend fusion when there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. The medical records fail to establish that there was instability at the L4-5 and L5-S1 regions to support the need for fusion. In addition, there is a lack of documentation of smoking status, which would be pertinent to know prior to considering surgical intervention of the lumbar spine in the form of a fusion. Documentation also fails to establish the psychosocial screen or that an attempt, failure, and exhaustive conservative treatment failed to yield any significant meaningful results prior to considering surgical intervention. Therefore, based on the documentation presented for review and in accordance with California ACOEM, and Official Disability Guidelines, the request for the L4-5 and L5-S1 bilateral laminectomy with medial facetectomy, and discectomy followed by fusion cannot be considered medically necessary.

Postoperative Aquatic Therapy three (3) times a week for six (6) weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Lumbar Sacral Orthoses (LSO) Back Brace: 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 chapter - Back brace, post operative (fusion).

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

Routine Preoperative Medical Work-up: 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 ACOEM), 2nd Edition, (2004) ACOEM Chapter 7, page 127.

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

