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| Case Number: | CM14-0074477 | | |
| Date Assigned: | 07/16/2014 | Date of Injury: | 01/20/2013 |
| Decision Date: | 08/14/2014 | UR Denial Date: | 04/17/2014 |
| Priority: | Standard | Application Received: | 05/22/2014 |

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 MTUS/ACOEM Guidelines, revised low back disorder guidelines recommend lumbar discectomy for patients with radiculopathy due to on-going nerve root compression who continue to have significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. Decompression surgery is an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability has been proven. Guideline indications include radicular pain syndrome with current dermatomal pain and/or numbness, or myotomal muscle weakness all consistent with a herniated disc. Imaging findings are required that confirm persisting nerve root compression at the level and on the side predicted by the history and clinical examination. There must be continued significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. The Official Disability Guidelines indicate that fusion may be supported for surgically induced segmental instability but pre-operative guidelines recommend completion of all physical medicine and manual therapy interventions and psychosocial screen with all confounding issues addressed. Guideline criteria have not been met. There is no clinical evidence presented to support the medical necessity of surgical intervention and consistent with imaging. There is no clear imaging evidence of stenosis or neural compression. There is no documentation of radiculopathy or functional limitation. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Furthermore, there is no radiographic evidence of segmental instability. A psychosocial screen is not evidenced. Therefore, the request for L5/S1 anterior lumbar fusion, discectomy decompression and instrumentation is not medically necessary and appropriate.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 Anterior lumbar fusion, discectomy decompression and Instrumentation: 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) ODG-TWC Low Back Procedure Summary last updated 03/31/2014 Indications for surgery discectomy/laminectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-211.

Decision rationale: The MTUS/ACOEM Guidelines, revised low back disorder guidelines recommend lumbar discectomy for patients with radiculopathy due to on-going nerve root compression who continue to have significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. Decompression surgery is an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability has been proven. Guideline indications include radicular pain syndrome with current dermatomal pain and/or numbness, or myotomal muscle weakness all consistent with a herniated disc. Imaging findings are required that confirm persisting nerve root compression at the level and on the side predicted by the history and clinical examination. There must be continued significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. The Official Disability Guidelines indicate that fusion may be supported for surgically induced segmental instability but pre-operative guidelines recommend completion of all physical medicine and manual therapy interventions and psychosocial screen with all confounding issues addressed. Guideline criteria have not been met. There is no clinical evidence presented to support the medical necessity of surgical intervention and consistent with imaging. There is no clear imaging evidence of stenosis or neural compression. There is no documentation of radiculopathy or functional limitation. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Furthermore, there is no radiographic evidence of segmental instability. A psychosocial screen is not evidenced. Therefore, the request for L5/S1 anterior lumbar fusion, discectomy decompression and instrumentation is not medically necessary and appropriate.

Neuromonitoring for 7 days inpatient stay: 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) ODG-TWC Low Back Procedure Summary last updated 3/31/2014 ODG Hospital length of stay (LOS) guidelines.

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), Intraoperative neurophysiological monitoring (during surgery).

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