

Case Number:	CM14-0077341		
Date Assigned:	07/18/2014	Date of Injury:	01/10/2014
Decision Date:	08/15/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	05/27/2014

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 Orthopaedics 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 56-year-old female sustained an industrial injury on 1/10/14, relative to lifting heavy boxes. The 2/18/14 lumbar MRI impression documented congenitally short pedicles and epicondyle lipomatosis predisposing to acquired canal stenosis. There was a 3 mm L3/4 disc protrusion with moderate central canal stenosis. There was a 6 mm L4/5 left paracentral disc extrusion with an inferiorly migrating disc fragment contributing to moderately severe central canal stenosis. Focal central protrusion was noted from L2-L5 with mild central narrowing. There was multilevel facet arthrosis contributing to multilevel foraminal and lateral recess stenosis. There was a spondylitic osteophyte encroaching on the exiting nerve root at L5/S1. The 4/10/14 treating physician report indicated the patient had lower back and left foot pain, progressive weakness, left foot drop, and increasing left foot numbness. Lumbar spine exam showed severe tenderness to palpation, marked loss of range of motion, and positive left straight leg raise. Muscle testing documented 3/5 strength in the left tibialis anterior and 2/5 strength in the left extensor hallucis longus groups. There was decreased sensation in the left L5 dermatome. Lower extremity deep tendon reflexes were +2 and symmetrical. The provider stated the patient had a profound foot drop on the left side with congenital stenosis and large disc herniation which did not improve with treatment over the past 3 months. Due to congenital stenosis and osteophyte formation, surgery will require decompression and fusion to adequately decompress the neural elements, requiring removal of a large portion of the facets at L4/5 and L5/S1. The 5/14/14 utilization review denied the request for L4-S1 anterior fusion with instrumentation and associated items as decompression of the disc herniation and removal of the extruded disc should not destabilize the L4/5 level and psychological clearance was not documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 Anterior Lumbar Fusion, w/instrumentation, Allograft bone: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back (updated 03/31/14) Fusion (spinal)Allograft transplantation, see Transplantation, intervertebral disc.

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

Decision rationale: The ACOEM 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. 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 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. The provider has indicated that surgical decompression will require removal of a large portion of the facets at L4/5 and L5/S1 creating instability. Progressive neurologic dysfunction is documented. Reasonable conservative treatment has been tried and failed. However, a psychosocial screen is required and not evidenced. Therefore, this request for L4-S1 anterior lumbar fusion, with instrumentation and allograft bone is not medically necessary.

Pre-op Lumbar CT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: CT (computed tomography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 59.

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

Post-op Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Back brace, post operative (fusion).

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, Back brace, post operative (fusion).

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

Bone Growth Stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Bone Growth Stimulator (BGS).

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, Bone growth stimulators (BGS).

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