

Case Number:	CM14-0190046		
Date Assigned:	11/21/2014	Date of Injury:	03/15/2012
Decision Date:	01/09/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/14/2014

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 Georgia. 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 injured worker is a 44-year-old female who reported an injury on 03/15/2012. The mechanism of injury was noted as a fall. Her diagnoses included facet joint arthritis L4-5 and L5-S1. Previous treatments included facet joint injections at L4-5 and L5-S1. Diagnostic testing was not submitted for clinical review. Within the clinical documentation submitted on 05/19/2014 the operative note stated the injured worker underwent a facet joint injection at the bilateral L4-5 and L5-S1. The injured worker had complained of persistent back pain with severe facet joint arthritis. The documentation submitted on 08/14/2014 reported the injured worker complained of pain to her left wrist, left shoulder, and left hip, and left shin. A physical examination was not submitted for clinical review. A request was submitted for L4 and L5 anterior lumbar fusion, L3-4 artificial disc, L4-S1 lumbar posterior fusion, internal fixation, possible laminectomy, 4 to 5 day inpatient stay, assistant surgeon. However, a rationale was not submitted for clinical review. The request for authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 and L5-S1 Anterior Lumbar Fusion: 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: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

Decision rationale: The request for L4-5 and L5-S1 anterior lumbar fusion is not medically necessary. The California MTUS Guidelines state surgery is considered for low back symptoms after only when serious spinal pathology or nerve root dysfunction are not responsive to conservative therapy and there is documentation of severe or disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies. Activity limitations due to radiating leg pain for more than 1 month or extreme progression of lower leg symptoms. Clear clinical imaging and electrophysiological evidence of a lesion and failure of conservative treatment. Except for cases of trauma related to spinal fracture or dislocation, fusion of the spine is not usually considered during the first 3 months of symptoms. There is no scientific evidence with a long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. The clinical documentation submitted failed to include an adequate and complete physical examination warranting the medical necessity for the request. Imaging studies and/or electrophysiological testing were not submitted for clinical review. There is lack of significant documentation indicating the patient had a spinal fracture, dislocation, or spondylolisthesis, or if there is instability. Therefore, the request is not medically necessary.

L3-4 Artificial Disc: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Disc prosthesis.

Decision rationale: The request for L3-4 artificial disc is not medically necessary. The California MTUS Guidelines state that there should be clear clinical and electrophysiological evidence of a lesion that has been shown to benefit from both short and long term surgical repair and documentation of failure of conservative treatment to resolve disabling radicular symptoms. In addition, the Official Disability Guidelines indicate disc replacement is not recommended. Studies have failed to demonstrate superiority to disc replacement over lumbar fusion, which is also not a recommended treatment for degenerative disc disease. Furthermore, longevity of this new procedure is unknown. There is lack of significant clinical documentation warranting the medical necessity for the request. The provider failed to document an adequate and complete pain assessment within the documentation. Imaging studies were not submitted for clinical review. Additionally, the guidelines do not recommend the utilization of artificial discs. Therefore, the request is not medically necessary.

L4-S1 Lumbar Posterior Fusion: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

Decision rationale: The request for L4-S1 lumbar posterior fusion is not medically necessary. The California MTUS Guidelines state that there should be clear clinical and electrophysiological evidence of a lesion that has been shown to benefit from both short and long term surgical repair and documentation of failure of conservative treatment to resolve disabling radicular symptoms. In addition, the Official Disability Guidelines indicate disc replacement is not recommended. Studies have failed to demonstrate superiority to disc replacement over lumbar fusion, which is also not a recommended treatment for degenerative disc disease. Furthermore, longevity of this new procedure is unknown. There is lack of significant clinical documentation warranting the medical necessity for the request. The provider failed to document an adequate and complete pain assessment within the documentation. Imaging studies were not submitted for clinical review. Additionally, the guidelines do not recommend the utilization of artificial discs. Therefore, the request is not medically necessary.

Internal Fixation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

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

Possible Laminectomy: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

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

4-5 day 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) Hospital Length of Stay

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, Hospital length of stay (LOS)

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 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, Surgical assistant

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