MAXIMUS Federal Services

Case Number:	CM14-0202360		
Date Assigned:	12/12/2014	Date of Injury:	02/18/2004
Decision Date:	02/11/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/03/2014

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 Minnesota. 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 58-year-old female who sustained injuries to the lower back, right hip and right knee from a fall on April 18, 2004. She underwent a gastric bypass surgery and a total knee replacement arthroplasty in 2005, minor back surgery in 2006 and right shoulder surgery in 2012. An MRI of the lumbar spine was performed on 8/30/2014. The conclusions were remote compression fracture of T12 with anterior wedging, grade 1 anterolisthesis of L4 on L5 with 3 mm disc protrusion resulting in abutment of exiting nerve roots with narrowing of the neural foramina, 4 mm circumferential disc protrusion at L5-S1 with abutment of descending S1 nerve roots bilaterally as well as abutment of exiting right and left L5 nerve roots. On 10/1/14 an orthopedic spine consultation was performed. She had complaints of back pain radiating to both lower extremities, right greater than left. On examination range of motion was painful and straight leg raising was trace positive on the right and negative on the left. Sensory deficits were noted on the right side at L4, L5, and S1 dermatomes. There were lesser deficits on the left side at L4 and L5. There was no weakness or atrophy of the lower extremities. X-rays of the lumbosacral spine revealed multilevel spondylosis with grade 1 spondylolisthesis at L4-5. The documentation indicates that flexion/extension views were obtained but the official radiology report pertaining to the flexion/extension views is not submitted. A diagnosis of instability was based upon MRI findings of grade 1 spondylolisthesis at L4-5 and retrolisthesis at L5-S1 associated with disc space narrowing. A lumbar fusion and decompression was advised. The request for lumbar fusion and decompression/anterior lumbar interbody fusion at L4-5 and L5-S1 was noncertified by utilization review on 11/24/2014. The reason for the denial was lack of the requested radiology report pertaining to flexion/extension x-rays to determine segmental instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar decompression, anterior lumbar interbody fusion at L4-L5 and L5-S1: 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, 307, and 310.

Decision rationale: California MTUS guidelines indicate on page 310 that spinal fusion is not recommended in the absence of fracture, dislocation, complication of tumor, or infection. The documentation does not indicate the presence of any of the above. The guidelines indicate surgical considerations when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. With respect to spinal fusion the guidelines state that patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence that spinal fusion alone is effective for treating any type of acute low back problem in the absence of spinal fracture, dislocation, and spondylolisthesis if there is instability and motion in the segment operated on. Based upon this guideline the documentation of motion on flexion/extension films will be important to support the surgical request. The documentation at this time does not include an official radiology report pertaining to the flexion/extension films. The guidelines also indicate that lumbar fusion in patients with other types of low back pain very seldom cures the patient. Based upon the above guidelines, in the absence of demonstrable motion at the level of spondylolisthesis and in the absence of a fracture, dislocation, complication of tumor, or infection, the request for a spinal fusion is not supported. The documentation also indicates negative straight leg raising. There is no electrophysiologic evidence of radiculopathy documented. In light of the above, the request for lumbar decompression and anterior lumbar interbody fusion at L4-5 and L5-S1 is not supported by guidelines and as such, the medical necessity of the request is not medically necessary.

Associated surgical service: standard pre-op medical clearance: 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, 307, and 310.

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

Associated surgical service: supervised post operative rehab therapy; 12 sessions, 3 times a week for 4 weeks: 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, 307, and 310.

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

Associated surgical service: game ready cold unit: 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, 307, and 310.

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

Associated surgical service: lumbar external bone stimulator: 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, 307, and 310.

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

Associated surgical service: TLSO brace: 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, 307, and 310.

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

Associated surgical service: front wheel walker: 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, 307, and 310.

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

Associated surgical service: 3 in 1 commode: 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, 307, and 310.

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