MAXIMUS Federal Services

Case Number:	CM14-0081517		
Date Assigned:	07/18/2014	Date of Injury:	09/13/2012
Decision Date:	01/02/2015	UR Denial Date:	05/08/2014
Priority:	Standard	Application Received:	06/02/2014

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 Spine 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 injured worker is a 42-year-old male who reported an injury on 09/13/2012. The surgical history was not provided. The injured worker's medications included Xanax, Percocet, and Wellbutrin. The documentation indicated the injured worker was a current smoker. The mechanism of injury was the injured worker was repetitively lifting 35 pounds to 55 pound batteries. Prior therapy included acupuncture and physical therapy as well as medications. The documentation of 04/14/2014 revealed the injured worker was utilizing Percocet 10/325 mg every 12 hours, Wellbutrin SR 150 mg, Valium 10 mg 4 times daily and Restoril 30 mg. The injured worker was noted to smoke occasionally socially. The physical examination noted sensation was normal along all dermatomes in the dorsal spine. The injured worker had moderate to severe pain across the low back. Range of motion was restricted. There was decreased sensation across the right L5 distribution and weakness of 4/5. The documentation indicated the injured worker's leg was giving out on him. The injured worker had a positive straight leg raise at 70 degrees and a positive Lasgue's. The injured worker was noted to undergo an x-ray of the lumbar spine on 11/14/2013, which revealed no evidence of acute fracture, pars defect or vertebral instability. There was minimal to mild discogenic spondylosis at L5-S1. There were no significant postural abnormalities. The documentation indicated the injured worker underwent an MRI of the lumbar spine on 05/27/2013, which revealed disc desiccation at L5-S1 with Modic type 2 degenerative changes involving the inferior endplate of L5 and superior endplate of S1. There was restricted range of motion in flexion and extension, which the physician opined on the examination of 04/14/2014, may reflect an element of mild spasm. There was subligamentous herniation without significant disc migration at L5-S1. At L5-S1 there was focal disc herniation measuring 8 mm in neutral, 6.7 mm in flexion and 6.7 mm in extension with concurrent bilateral facet degenerative changes as well as bilateral ligamentum

flavum hypertrophic causing bilateral neural foraminal and spinal canal stenosis. There was a hemangioma at the L5 vertebral body. The diagnoses included herniated nucleus pulposus and Modic type 2 changes at L5-S1 level, 8 mm disc protrusion at L5-S1 and bilateral neural foraminal narrowing and spinal stenosis. The treatment plan included a lumbar fusion at L5-S1 through anterior and posterior technique. There was no Request for Authorization submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior and Posterior Lumbar Fusion, graft instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines ODG-TWC Low Back Procedure Summary last updated 03/31/2014 Patient selection for lumbar spinal fusion

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and 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 documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Clinicians should consider referral for psychological screening to improve surgical outcomes. There would be no necessity for electrodiagnostic studies to support a fusion. The injured worker was noted to be undergoing psychological therapy. The injured worker was a current smoker and there was a lack of documentation indicating a discussion had taken place regarding cessation of smoking. Smoking can impede healing of a fusion. There was a lack of documentation indicating the injured worker was cleared for surgical intervention through the psychologist. There was a lack of documentation of the official MRI report. The request as submitted failed to indicate the levels for the requested surgical intervention. Given the above, the request for anterior and posterior lumbar fusion, graft instrumentation is not medically necessary.

Co-surgeon: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Intraoperative neuromonitoring: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Assist three (3) day inpatient stay: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Post-op Physical Therapy three (3) times four (4): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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