

Case Number:	CM15-0106135		
Date Assigned:	06/10/2015	Date of Injury:	10/16/2008
Decision Date:	07/13/2015	UR Denial Date:	05/29/2015
Priority:	Standard	Application Received:	06/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Neurological Surgery

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 female, who sustained an industrial injury on 10/16/2008. She has reported injury to the low back. The diagnoses have included lumbago; lumbar disc degeneration; cervicgia; shoulder pain; reflex sympathetic dystrophy upper extremity; sacroiliitis; and chronic pain syndrome. Treatment to date has included medications, diagnostics, cervical spinal cord stimulator placement, and physical therapy. Medications have included Percocet, Cymbalta, and Xanax. A progress report from the treating physician, dated 02/10/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of significant pain in the low back. Objective findings included gait evaluation demonstrated stooping; hunched forward and unable to straighten up; tenderness on palpation of the lower level lumbar spinous processes; extension was restricted; there is breakaway weakness due to back pain in the right lower extremity; and strength is 4/5. The treatment plan has included the request for bilateral lumbar L4-S1 (sacroiliac) laminectomy; medial facetectomy and foraminotomy lumbar L4-L5 and L5-S1 (sacroiliac); transforaminal interbody fusion with placement of peek interbody graft; placement of bilateral titanium pedicle screws and rods, lumbar L4-S1 (sacroiliac); posterior lateral fusion with local autograft and cadaver allograft, lumbar L4-S1 (sacroiliac); lumbar brace; and bone stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Lumbar L4-S1 (sacroiliac) Laminectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. Documentation does not provide this evidence. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment is also connected with the request for a lumbar fusion. The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Bilateral Lumbar L4-S1 (sacroiliac) Laminectomy is not medically necessary and appropriate.

Medial Facetectomy and Foraminotomy Lumbar L4-L5 and L5-S1 (sacroiliac): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. Documentation does not provide this evidence. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment is also connected with the request for a lumbar fusion. The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Medial Facetectomy and Foraminotomy Lumbar L4-L5 and L5-S1 (sacroiliac) is not medically necessary and appropriate.

Transforaminal Interbody Fusion with placement of peek interbody graft: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Transforaminal Interbody Fusion with placement of peek interbody graft is not medically necessary and appropriate.

Placement of Bilateral Titanium Pedicle screws and rods, Lumbar L4-S1 (sacroiliac):
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Placement of Bilateral Titanium Pedicle screws and rods, Lumbar L4-S1 is not medically necessary and appropriate.

Posterior Lateral Fusion with local Autograft and Cadaver Allograft, Lumbar L4-S1 (sacroiliac): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Posterior Lateral Fusion with local Autograft and Cadaver Allograft, Lumbar L4-S1 (sacroiliac) is not medically necessary and appropriate.

Associated surgical services: Lumbar brace: 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.

Associated surgical services: Bone stimulator: 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.