

Case Number:	CM15-0010618		
Date Assigned:	01/28/2015	Date of Injury:	02/25/2000
Decision Date:	04/06/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	01/20/2015

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:

This 70 year old male retired firefighter insulin dependent diabetic had onset of low back hip and leg pain in 1994. He fell in a hole and in 1999 reinjured his back fighting a fire and then retired after he sustained an industrial injury on 2/25/2000. He reports back and bilateral hip and leg pain. His diagnoses have included lumbar spinal stenosis and spondylolisthesis. However, the radiologist noted on the myelogram done on 10/30/2014 there were no changes in flexion and extension in the L3-4 retrolisthesis. The post-myelogram computerized scan of 10/30/2014 noted moderate to severe lumbar disc disease with bilateral moderate to severe stenosis with nerve root compromise. The PR2 exam on the other hand on 10/8/2014 noted normal strength, intact reflexes, negative straight leg raising and a normal gait. Treatment to date has included medications, surgeries, 7 lumbar epidural steroid injections, physical therapy, pool therapy, and diagnostics. Currently, the injured worker complains of low back pain, bilateral leg pain and difficulty walking. The pain is intermittent, dull and aching. He used to have shooting pain down bilateral extremities but has none since hip replacement. He has intermittent parasthesias of the whole left leg. The pain is worse with standing/sitting. He has had seven epidural steroid injections with only some relief. He states that physical therapy did not help and pool therapy only relieved the pain while in the water. Physical exam revealed paraesthesias in the bilateral lower extremities. The injured worker feels that he is getting worse. The left leg pain is worse than his low back pain. The Magnetic Resonance Imaging (MRI) of the lumbosacral spine dated 8/12/14 revealed central disc protrusion, neuroforaminal narrowing, facet hypertrophy, and annular bulge. The lumbar myelogram dated 10/30/14 revealed severe degenerative disc disease

with stenosis and nerve root compression. There is also left disc bulge with effacement. Treatment was surgical intervention. On 12/16/14 Utilization Review non-certified a request for Left L2-3 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation, Left L3-4 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation, Left L4-5 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation, Bone growth stimulator, Facility medical center and TLSO brace, noting that regarding the request for Left L2-3 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation, Left L3-4 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation although the injured worker may be a candidate for decompression at the requested levels the medical necessity for 3 level lumbar fusion in this individual is not demonstrated in the absence of gross instability or a severe deformity. Regarding the Bone growth stimulator, Facility medical center and TLSO brace, these issues will not be addressed as surgery is denied. The (MTUS) Medical Treatment Utilization Schedule, (ACOEM) Occupational Medicine Practice Guidelines and Official Disability Guidelines (ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L2-3 posterior oblique lumbar arthrodesis posterolateral fusion 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, Low Back, Fusion.

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

Decision rationale: The California MTUS guidelines note that there is no scientific evidence for long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis. Indeed the guidelines note that fusion would be indicated for the patient with a fracture dislocation or instability. This patient has not had a fracture or dislocation and he has had imaging that does not show instability. The MTUS guidelines also note that surgery can be considered when there is clear clinical, imaging and electrophysiological evidence of a lesion which would respond in both the short and long-term to surgical repair. This patient's exam and history does not point to such a lesion. Thus the requested treatment: L2-3 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation is not medically necessary and appropriate.

Left L3-4 posterior oblique lumbar arthrodesis posterolateral fusion 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, Low Back, Fusion.

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

Decision rationale: The California MTUS guidelines note that there is no scientific evidence for long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis. Indeed the guidelines note that fusion would be indicated for the patient with a fracture dislocation or instability. This patient has not had a fracture or dislocation and he has had imaging that does not show instability. The MTUS guidelines also note that surgery can be considered when there is clear clinical, imaging and electrophysiological evidence of a lesion which would respond in both the short and long-term to surgical repair. This patient's exam and history does not point to such a lesion. Thus the requested treatment: L2-3 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation is not medically necessary and appropriate.

Left L4-5 posterior oblique lumbar arthrodesis posterolateral fusion 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, Low Back, Fusion.

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

Decision rationale: The California MTUS guidelines note that there is no scientific evidence for long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis. Indeed the guidelines note that fusion would be indicated for the patient with a fracture dislocation or instability. This patient has not had a fracture or dislocation and he has had imaging that does not show instability. The MTUS guidelines also note that surgery can be considered when there is clear clinical, imaging and electrophysiological evidence of a lesion which would respond in both the short and long-term to surgical repair. This patient's exam and history does not point to such a lesion. Thus the requested treatment: L2-3 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation is not medically necessary and appropriate.

Bone growth stimulator: 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 Since the requested treatment: L2-3 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation is not medically necessary and appropriate, then the requested treatment: bone growth stimulator is not medically necessary and appropriate.

Decision rationale: Since the requested treatment: L2-3 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation is not medically necessary and appropriate, then the requested treatment: bone growth stimulator is not medically necessary and appropriate.

Facility medical center: 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 Since the requested treatment: L2-3 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation is not medically necessary and appropriate, then the requested treatment: facility medical center is not medically necessary and appropriate.

Decision rationale: Since the requested treatment: L2-3 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation is not medically necessary and appropriate, then the requested treatment: facility medical center is not medically necessary and appropriate.

TLSO brace: 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 Since the requested treatment: L2-3 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation is not medically necessary and appropriate, then the requested treatment: TLSO brace is not medically necessary and appropriate.

Decision rationale: Since the requested treatment: L2-3 posterior oblique lumbar arthrodesis posterolateral fusion instrumentation is not medically necessary and appropriate, then the requested treatment: TLSO brace is not medically necessary and appropriate.