

Case Number:	CM15-0012030		
Date Assigned:	01/29/2015	Date of Injury:	11/12/1999
Decision Date:	04/24/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/21/2015

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: Texas

Certification(s)/Specialty: Orthopedic 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 67-year-old female who reported an injury on 11/12/1999. The injured worker reportedly suffered a low back strain while attempting to catch a falling client. The current diagnoses include adjacent segment collapse and scoliosis at L1-L3, remote lumbar laminectomy, and remote fusion from L3 through S1 with segmental hardware. On 12/08/2014, the injured worker underwent a follow-up evaluation with complaints of persistent low back pain. Upon examination, there was decreased lumbar range of motion, negative straight leg raise, negative tenderness, 4/5 motor weakness on the right, and diminished patellar and Achilles reflexes bilaterally. Recommendations included a direct lateral discectomy and fusion at L1-3 combined with a posterior stabilization. A request for authorization form was then submitted on 12/17/2014. The official MRI of the lumbar spine, dated 11/24/2014, was provided for this review and revealed evidence of a 7 mm disc osteophyte complex at L2-3 causing left lateral recess narrowing and severe bilateral neural foraminal narrowing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Direct Lateral Discectomy and Fusion at L1-L2, L2-L3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines: Treatment Index, 13th Edition (web), 2015, Low Back, Fusion (spinal).

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 Chapter, Fusion (spinal).

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. In this case, there was no documentation of a significant functional limitation upon examination. There was no mention of an exhaustion of any recent conservative treatment. There was no evidence of spinal instability upon flexion and extension view radiographs. There was also no documentation of a psychosocial screening completed prior to the request for a lumbar fusion. Given the above, the request is not medically appropriate.

L1 to L2 Laminectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 13th Edition (web), 2015, Low Back, Fusion (spinal).

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 Chapter, Discectomy/Laminectomy.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines recommend a discectomy/laminectomy when there is evidence of radiculopathy upon examination. Imaging studies should reveal lateral disc rupture, lateral recess stenosis, or nerve root impingement. Conservative treatment should include activity modification, drug therapy and epidural steroid injection. There should also be evidence of a referral to physical therapy, manual therapy or the completion of a psychological screening. In this case, there was no documentation of a significant functional limitation upon examination. The request for an L1 to L2 laminectomy was submitted in conjunction with a lateral discectomy and fusion. The injured worker's lateral discectomy and fusion at L1 to L3 has not been authorized. Therefore, the associated procedure is not medically necessary.

Posterior T10 to L3 Fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 13th Edition (web), 2015, Low Back, Fusion (spinal).

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 Chapter, Fusion (spinal).

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. In this case, there was no documentation of a significant functional limitation upon examination. There was no mention of an exhaustion of any recent conservative treatment. There was no evidence of spinal instability upon flexion and extension view radiographs. There was also no documentation of a psychosocial screening completed prior to the request for a lumbar fusion. Given the above, the request is not medically appropriate.

Assistant Surgeon (for 3 approaches): 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.

Length of Stay (LOS): 3-days: 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.

Pre-Operative History and Physical (for surgery clearance): 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.

Pre-Operative Labs: CBC with Diff, CMP, PT, PTT, UA: 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.

Pre-Operative Diagnostic Test: EKG: 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.

Pre-Operative Diagnostic Test: Chest X-ray: 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: DME Purchase: TLSO Back Bone: 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: Intraoperative Spinal Cord Monitoring: 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.