

Case Number:	CM15-0163919		
Date Assigned:	09/02/2015	Date of Injury:	08/09/2014
Decision Date:	10/28/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/21/2015

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: New York, Montana

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 40 year old female who sustained an injury on 8-9-14 resulting from doing customary duties as a housekeeper developed low back pain. A comprehensive pain management consultation exam on 5-4-15 her complaints are constant, stabbing, burning, low back pain that is rated 9 out of 10; radiates down both legs; associated with numbness and tingling. The pain is aggravated by prolonged sitting, standing and walking. Ibuprofen, heat and hot baths provide temporary relief. Medications include Norflex 100 mg, Omeprazole and Losartan. She is currently not working. Physical examination has moderate left greater than right-sided lower lumbar paraspinal muscle and upper gluteal muscle tenderness to palpation; lumbar spine testing shows limited range of motion in flexion at 80 degrees, extension at 10 degrees, and lateral flexion at 15 degrees bilaterally; lower extremity exam reveals no obvious deformities or joint swelling. Diagnoses are lumbar herniated nucleus pulposus at L5-S1 and lumbar radiculopathy. MRI left knee 3-24-15 show no evidence of internal derangement of the knee; deep chondral fissuring in the deep medial trochlea with underlying subchondral reactive marrow changes. MRI lumbar spine shows left paracentral disc protrusion at L5-S1 resulting in moderate left foraminal stenosis and contact with the traversing S1 nerve root. 6-15-15 lumbar translaminar epidural steroid injection at L5-S1 was performed. 6-24-15 PR2 reports she is complaining of diffuse low back pain radiating into bilateral lower extremities made worse with activity. The letter of 7/31/15 states the MRI scan of 3/24 shows a disc herniation eccentric to the right at L5-S1 and relates the patient exam shows significant reduction of range of motion in all planes. The PR2s of 7/28 and 8/17 show forward flexion to

80 degrees and straight leg raising positive at 20 degrees bilaterally with negative Laseques maneuvers. This is not explained. The exam further states the patient has a normal lumbar lordosis with a normal gait and station, able to heel and toe walk. Conservative treatment has included physical therapy, medication, and chiropractic in the past 6 months with no improvement of her pain. Work restrictions are continue modified duties, no prolonged standing or walking, no climbing, bending or stopping; no squatting; kneeling; pivoting and no weight lifting above 5 lbs. Surgery was the recommendation at this time. Current requested treatments Anterior lumbar Interbody fusion L5- S1; Associated surgical service: 3 day inpatient stay; Associated surgical service: Neurophysiology monitoring during surgery; Post-operative lumbar brace for lumbar spine for unknown duration; Post-operative front wheeled walker for lumbar spine; Post-operative, physical therapy for lumbar spine, 3 times a week for 4 weeks (12 sessions); Post-operative 3 in 1 commode for lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior lumbar interbody fusion L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM 2013, Low Back Disorders; ODG, Low Back Disorders.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: The California MTUS guidelines recommend lumbar surgery if there are severe persistent, debilitating lower extremity complaints, clear clinical and imaging evidence of a specific lesion corresponding to a nerve root or spinal cord level, corroborated by electrophysiological studies which are known to respond to surgical repair both in the near and long term. Documentation does not provide this evidence. Magnetic resonance imaging scan (MRI) showed no severe canal or foraminal stenosis or nerve root impingement. Her provider recommends an anterior interbody lumbar arthrodesis to treat her low back pain and radiculopathy. Documentation does not present evidence of instability. The California MTUS does recommend fusion for fracture and dislocation and instability. The patient has not had a fracture. According to the Guidelines for the performance of fusion procedures for degenerative diseases of the lumbar spine, published by the joint section of the American Association of Neurological surgeons and Congress of Neurological Surgeons in 2005, there was no convincing medical evidence to support the routine use of lumbar fusion at the time of primary lumbar disc excision. This recommendation was not changed in the update of 2014. The update did note that fusion might be an option if there is evidence of spinal instability, chronic low back pain, and severe degenerative changes. Documentation does not show instability or severe degenerative changes. The documentation does not support California MTUS criteria that the requested treatment: Anterior lumbar interbody fusion L5-S1 is medically reasonable and necessary. Therefore the request is not medically necessary.

Associated surgical service: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: Neurophysiology monitoring during surgery: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-operative lumbar brace for lumbar spine: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-operative bone growth stimulator for lumbar spine for unknown duration: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-operative front wheeled walker for lumbar spine: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-operative physical therapy for lumbar spine, 3 times a week for 4 weeks (12 sessions):
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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-operative 3 in 1 commode for lumbar spine: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.