

Case Number:	CM15-0190614		
Date Assigned:	10/05/2015	Date of Injury:	04/12/2012
Decision Date:	11/18/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	09/28/2015

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: Minnesota, Florida
 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 53 year old female injured worker suffered an industrial injury on 4-12-2012. The diagnoses included displacement of the lumbar intervertebral disc without myelopathy, degeneration of the lumbar intervertebral disc and spinal stenosis of the lumbar spine. On 9-9- 2015 the treating provider reported the request surgical intervention as it would address both issues of her radicular pain and lower back pain. She reported numbness in the right foot and she did not improve with epidural steroid injection. On exam the lumbar spine had moderate tenderness and painful reduced range of motion. The left ankle reflex was absent. The straight leg raises and cross straight leg raise were positive. Prior treatment included lumbar laminectomy 7-22-2013, physical therapy, medication and epidural steroid injection. Diagnostics included lumbar magnetic resonance imaging 8-19-2015. Request for Authorization date was 9-10-2015. The Utilization Review on 9-17-2015 determined non-certification for Transforaminal Lumbar Interbody Fusion and Posterior Lateral Pedicle Fusion L5-S1 (Bilateral Laminectomy L5-S1) with associated services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Lumbar Interbody Fusion and Posterior Lateral Pedicle Fusion L5-S1 (Bilateral Laminectomy L5-S1): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Indications for Laminectomy/Discectomy/Fusion.

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

Decision rationale: California MTUS guidelines indicate surgical consultation for patients who have severe disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitation due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, 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 failure of conservative treatment to resolve disabling radicular symptoms. In this case the EMG and nerve conduction study was negative. The MRI scan shows a bulge with abutment against the right S1 nerve root. However, the right Achilles reflex is intact. The radicular pain is in both lower extremities, more on the right. There is no spondylolisthesis or instability documented. The guidelines indicate a surgical fusion for patients with increased spinal instability after decompression at the level of degenerative spondylolisthesis. There is no documentation of angular or translational instability on flexion/extension films. A fusion is also indicated for spinal fracture, dislocation or complications of tumor or infection which is not the case here. Lumbar fusion in patients with other types of low back pain very seldom cures the patient. As such, the guidelines do not support a spinal fusion in this case and the medical necessity of the request has not been substantiated.

Associated Surgical Service: Intraoperative neuro monitoring-EMG/SS EP: 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 surgical procedure is not medically necessary, none of the associated surgical requests are applicable.

Associated Surgical Service: Pedicle screw stimulation: 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 surgical procedure is not medically necessary, none of the associated surgical requests are applicable.