

Case Number:	CM15-0202033		
Date Assigned:	10/16/2015	Date of Injury:	12/07/2010
Decision Date:	12/03/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	10/14/2015

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, California
 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 47-year-old male, who sustained an industrial injury on 12-07-2010. He has reported injury to the low back. The diagnoses have included L3-S1 disc herniations with bilateral foraminal stenosis greater towards the right hand side; advanced disc deterioration L4-S1 with Grade I plus modic changes, end plate deterioration, loss of T2 signal intensity; significant arthropathy L4 through S1; and annular tear at L5-S1. Treatments have included medications, diagnostics, activity modification, lumbar epidural steroid injections, acupuncture, physical therapy, and surgical intervention. Medications have included Norco, Naproxen, Prilosec, and Menthoderm cream. A progress report from the treating provider, dated 09-01-2015, documented an evaluation with the injured worker. The injured worker reported severe mechanical axial back pain and right leg radiculopathy, including severe pain, numbness, and weakness mostly down the posterior portion of the legs, but also down the anterior thigh as well; he has neurogenic claudication and difficulty in ambulating distances; he has had prior decompression at L4-5, possibly L5-S1; and he has also undergone extensive conservative care including physical therapy, core strengthening exercise, and injections. Objective findings included slight limp towards the right leg; overall strength examination has a pain-related effort and weakness; his iliopsoas, quadriceps, and hamstrings are rated -5 out of 5 on the left and +4 out of 5 on the right; his anterior tibialis and extensor hallucis longus muscles are 4 out of 5 on the right and +4 out of 5 on the left; gastrocnemius muscles are a 4 out of 5 on the right and -5 out of 5 on the left; his sensation is diminished to right L4-L5, and S1 light touch dermatomal distribution; and reflexes are trace throughout. The provider noted that the MRI scan, dated 07-

16-2015, "shows significant discogenic changes at both the L4-5 and L5-S1 levels; there is midline disc herniation with central canal stenosis and there is also annular tear at the L5-S1 level; there is marked foraminal stenosis from L3 through S1 levels more towards the right than the left; and there is also marked facet arthropathy particularly at L5-S1 and L4-5 with severe inflammatory changes, bone spur formation, and arthropathy." The treatment plan has included the request for L4-S1 posterior spinal fusion and decompression combined with a bilateral L3-4 laminar foraminotomy and microdiscectomy; 2 inpatient days; post-op walker rental for 3 weeks; post-op lumbar brace for purchase; and post-op bone growth stimulator for 3-week rental. The original utilization review, dated 09-17-2015, non-certified the request for L4-S1 posterior spinal fusion and decompression combined with a bilateral L3-4 laminar foraminotomy and microdiscectomy; 2 inpatient days; post-op walker rental for 3 weeks; post-op lumbar brace for purchase; and post-op bone growth stimulator for 3 week rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 Posterior spinal fusion and decompression combined with a bilateral L3-4 laminar foraminotomy and microdiscectomy: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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

Decision rationale: California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of these conditions. His magnetic resonance imaging scan (MRI) showed no severe canal or foraminal stenosis or nerve root impingement. His provider recommended a posterior lumbar arthrodesis and decompression. Documentation does not present evidence of instability. 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. Therefore, the requested treatment is not medically necessary and appropriate.

2 Inpatient 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.

Post-op Walker rental for 3 weeks: 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.

Post-op lumbar brace for purchase: 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.

Post-op Bone Growth Stimulators for 3-week rental: 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.