

Case Number:	CM15-0206131		
Date Assigned:	10/22/2015	Date of Injury:	12/10/1987
Decision Date:	12/09/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/20/2015

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, 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 53 year old female, who sustained an industrial injury on 12-10-87. The injured worker was diagnosed as having thoracic or lumbosacral neuritis, lumbar spinal stenosis with neurogenic claudication, and lumbar post-laminectomy syndrome. Treatment to date has included 2 lumbar decompression and discectomies, physical therapy, aquatic therapy, transforaminal lumbar epidural steroid injections, a left sacroiliac joint block, and medication including Flexeril, Oxycodone, and Oxycontin. Physical examination findings on 9-16-15 included normal lumbar spine range of motion in extension, flexion, and side-bending. Inspection and palpation of the lumbar spine was noted to be within normal limits without erythema, swelling, deformity, or tenderness. Strength testing of the major muscles innervated by the lumbar spine was grades as 5 of 5 except for the left iliopsoas rated as 1 of 5, quadriceps 4 of 5, and anterior tibial as 1 of 5. Gait was noted to be normal. Electrodiagnostic studies obtained on 9-1-15 revealed left L5 radiculopathy with evidence of chronic denervation or reinnervation in the distal musculature without active evidence of active denervation. On 7-20-15 pain was rated as 6 of 10 with medication and 9 of 10 without medication. On 9-16-15, the injured worker complained of back pain with weakness and dysfunction of the left lower extremity. The treating physician requested authorization for anterolateral discectomy and fusion with posterior fusion and possible revision decompression on L4-5. Other requests included a 2 day inpatient stay, a surgery assistant, a lumbar brace, a front wheel walker, and a 3 in 1 commode. On 10-6-15 the requests were non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Anterolateral discectomy and fusion with posterior fusion and possible revision decompression on L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Discectomy/laminectomy, Fusion (spinal).

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

Decision rationale: The California MTUS guidelines do recommend lumbar surgery if there is clear clinical, electrophysiological and imaging evidence of specific nerve root or spinal cord level of impingement which would correlate with severe, persistent debilitating lower extremity pain unresponsive to conservative management. Documentation does not provide this evidence. Her magnetic resonance imaging scan (MRI) showed no severe canal or foraminal stenosis or nerve root impingement. Her provider recommended an anterolateral discectomy and lumbar fusion with a posterior fusion and possible revision and decompression on L4-5. 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. The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment Anterolateral discectomy and fusion with posterior fusion and possible revision decompression on L4-5 is not medically necessary and appropriate.

Associated surgical service: 2 in-patient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hospital length of stay.

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 service: 1 Surgery assistant: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee schedule search<http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

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 service: 1 lumbar brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic) - Lumbar supports.

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 service: 1 front wheel walker: 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 service: 1 3 in 1 commode: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic) - DME.

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.