MAXIMUS Federal Services

Case Number:	CM15-0020951		
Date Assigned:	02/10/2015	Date of Injury:	01/04/2011
Decision Date:	03/25/2015	UR Denial Date:	12/26/2014
Priority:	Standard	Application Received:	02/03/2015

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: Illinois, California, 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 54-year-old female who sustained a work related injury on 1/4/11. Injury to her back occurred when she tried to pick up a large adult male who fell from a wheelchair. Past surgical history was positive for C5/6 and C6/7 anterior cervical discectomy and fusion in 2002, and spinal cord stimulator implant in 2004 followed by removal in 2013. Conservative treatment has included activity modification, medications, trigger point injections, and home therapy. The 7/3/12 lumbar CT scan findings documented 3-4 mm disc protrusions at L2/3, L3/4, and L4/5 with bilateral neuroforaminal stenosis, most significant on the left at L3/4 with moderate neuroforaminal stenosis. The 7/16/13 lumbar spine MRI impression documented 3.7 mm circumference disc bulges with moderate disc desiccation and moderate neuroforaminal narrowing with a posterior annular tear at L3/4 and L4/5, and to a lesser extent at L5/S1. Electrodiagnostic studies on 12/6/13 reportedly demonstrated mild bilateral L5 radiculopathy, and new bilateral S1 radiculopathy with on-going denervation due to left S1 radiculopathy. The 11/12/14 treating physician report cited persistent low back pain with radicular symptoms to both lower extremities. Pain was reported with any movement which limited her mobility and activity tolerance. Current oral analgesic medications, including OxyContin, Norco, Anaprox, and Flexeril enabled her to function on a daily basis. Neurontin reduced her radicular symptoms by 40%. She had urinary incontinence symptoms that were being addressed by an urologist. Physical exam documented profound antalgia favoring the left lower extremity, and difficulty sitting. Physical exam documented paravertebral muscle and sciatic notch tenderness. There was mild loss of lumbar range of motion, absent left Achilles reflex, and positive bilateral straight leg

raise. There was decreased sensation along the left posterior lateral thigh, lateral calf, and dorsum of the foot. There was 4/5 weakness in left knee extension, ankle extension, and great toe extension. The treating physician stated the 5/19/14 lumbar provocative discogram was unequivocally positive at L4/5 and L5/S1. Lumbar fusion at L4/5 and L5/S1 was recommended. The 12/12/14 psychological evaluation report documented a diagnosis of cognitive disorder, major depressive disorder. The treatment plan recommended follow-up psychological evaluations, and treatment to included cognitive behavioral therapy and biofeedback. There was no statement that the patient was psychologically cleared for surgery. On 12/26/14, a request for a lumbar fusion at L4/5 and L5/S1, a bone growth stimulator and preoperative clearance was non-certified by Utilization Review, noting California Medical Treatment Utilization Schedule Guidelines and American College of Occupational and Environmental Medicine Guidelines. The rationale for non-certification documented no evidence of spinal segmental instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar fusion at L4-5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back ? Lumbar & Thoracic: Fusion (spinal)

Decision rationale: The California MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there was no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. This patient presents with persistent low back pain radiating to the lower extremities. There is significant functional impairment. Clinical exam findings are consistent with imaging evidence of plausible neural compression and electrodiagnostic evidence of L5 and S1 radiculopathy. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no radiographic evidence of spinal segmental instability. There is no evidence that psychological clearance has been given for surgery, with treatment recommendations noted relative to significant psychological symptoms. Therefore, this request is not medically necessary.

Post-op bone growth stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back Lumbar & Thoracic: Bone growth stimulator (BGS)

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-op clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.