

Case Number:	CM15-0026233		
Date Assigned:	02/18/2015	Date of Injury:	08/07/2013
Decision Date:	04/21/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	02/11/2015

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: California

Certification(s)/Specialty: Pediatrics, 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 38-year-old male who reported an injury on 08/07/2013. The mechanism of injury was not specifically stated. The current diagnosis is lumbar spondylolisthesis at L5-S1. The injured worker presented on 10/14/2014 for a re-evaluation with complaints of persistent low back pain. It was noted that the injured worker had been previously diagnosed with a bilateral pars defect and grade 1 spondylolisthesis of L5 on S1. The provider indicated that the options of surgery were discussed with the injured worker. The injured worker opted for conservative treatment and had subsequently undergone 2 lumbar injections without relief of symptoms. The current medication regimen includes cyclobenzaprine 10 mg and meloxicam 15 mg. Upon examination, there was a normal gait, unassisted, without difficulty. The injured worker was able to forward bend to 45 degrees with limitations secondary to pain, and extend to 10 degrees. The injured worker was able to heel and toe walk without weakness. There was no evidence of a positive straight leg raise in the bilateral lower extremities. The deep tendon reflexes were diminished at the bilateral knees and ankles. Motor strength was 5/5. The injured worker requested to proceed with surgery in 02/2015. It is also noted that the injured worker underwent an MRI of the lumbar spine on 02/13/2014, which revealed moderately severe degenerative discopathy at L5-S1 due to bilateral spondylosis defects and a grade 1 spondylolisthesis. There was no neural impingement noted. There were no other significant abnormalities identified. A Request for Authorization Form was then submitted on 01/06/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Laminectomy of Gill Fragment L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment Index, 12th Edition (web), 2014, Low Back, Fusion.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Discectomy/Laminectomy.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines recommend a laminectomy when there is objective evidence of radiculopathy upon examination. Imaging studies should reveal nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment should include activity modification, drug therapy, epidural steroid injection, physical therapy, or manual therapy. While it is noted that the injured worker has been treated with medications and epidural steroid injection, there was no evidence of an attempt at recent physical or manual therapy. There was no documentation of radiculopathy upon examination. Given the above, the request is not medically necessary at this time.

Posterior Lumbar fusion L5-S1 with Spacer, bone Graft and Pedicle Screw Fixation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment Index, 12th Edition (web), 2014, Low Back, Fusion.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (spinal).

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. In this case, there was no documentation of an exhaustion of conservative treatment to include a recent course of active

rehabilitation. Additionally, there was no evidence of spinal instability upon flexion and extension view radiographs. There was no documentation of a psychosocial screening completed prior to the request for a lumbar fusion. Given the above, the request is not medically necessary.

Associate Surgical Services: Post-Op DME Purchase: TLSO Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment Index, 12th Edition (web), 2014, Low Back, Fusion.

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 Services: Post-Op DME Purchase: Bone Stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment Index, 12th Edition (web), 2014, Low Back, Fusion.

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.