

Case Number:	CM15-0026920		
Date Assigned:	02/19/2015	Date of Injury:	07/16/2013
Decision Date:	03/31/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/12/2015

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 60-year-old male who sustained an industrial injury on 07/16/13, relative to a slip and fall. The 3/3/14 electrodiagnostic study documented minimal to mild S1 radiculopathy. The 9/30/14 treating physician report cited progressively worsening low back pain radiating down both calves with muscle spasms. He reported that the left leg was getting weaker. He had completed 12 sessions of chiropractic treatment that made his back worse. Physical exam documented mild to moderate loss of range of motion, absent left Achilles reflex and significant loss of sensation in the left L5 dermatome and slight loss in the L4 dermatome. An updated lumbar MRI was requested. The 10/14/14 lumbar spine MRI documented a left laminotomy defect at L5/S1. There was a disc bulge at L4/5 with facet hypertrophy, and mild canal and mild to moderate foraminal stenosis. There were disc bulges at L3/4/4 and L4/5 with facet hypertrophy and mild canal and mild to moderate foraminal stenosis. The 11/13/14 treating physician report cited low back pain and bilateral hamstring pain with chief complaint of left leg weakness and numbness. Back pain was worse with walking 2 to 3 blocks. He attended pool therapy and was attending physical therapy without sustained benefit. Chiropractic treatment made his symptoms worse. There was 4/5 left tibialis anterior weakness and decreased sensation in the left lateral thigh, calf and foot. The 12/11/14 treatment plan recommended anterior lumbar interbody fusion at L5/S1. Utilization review performed on 01/28/15 non-certified a request for L5-S1 anterior lumbar interbody fusion, Aspen Lumbar Sacral Orthosis (LSO) brace, and inpatient stay for two days. The rationale indicated that the clinical information submitted does

not support medical necessity of fusion. The reviewer referenced the California MTUS, ACOEM, and Official Disability Guidelines in making this decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 Anterior Lumbar Interbody fusion with [REDACTED] for anterior exposure:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301, 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Chapter; AMA Guides (Radiculopathy, Instability) Decompression; 5th Edition, page 382-383

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation 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 guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. 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 signs/symptoms and clinical exam findings consistent with imaging and electrodiagnostic evidence of plausible neural compression at L5/S1. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is no radiographic evidence of spinal segmental instability. A psychosocial screening is not evidenced. Therefore, this request is not medically necessary at this time.

Aspen LSO Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301, 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines; Low Back, Lumbar support

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

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

Associated Surgical Service: In-Patient stay two days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301, 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines; Hospital Length of stay (LOS) guidelines; Lumbar Spine Discectomy,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back: Lumbar & Thoracic: Hospital length of stay (LOS)

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