

Case Number:	CM15-0045833		
Date Assigned:	03/18/2015	Date of Injury:	10/18/2007
Decision Date:	05/05/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	03/10/2015

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 67-year-old female who sustained an industrial injury on 10/18/07. The mechanism of injury was not documented. The injured worker was diagnosed with: status post left total knee replacement with poor result, and revision; status post lumbar microdiscectomy with MRI findings of significant multilevel degenerative disc disease, canal stenosis, and severe foraminal stenosis at multiple levels; grade 1 anterolisthesis L4/5 and L5/S1; right hip bursitis, arthralgia, and degenerative joint disease; and right knee medial compartment osteoarthritis. The 12/9/12 EMG report documented generalized sensory polyneuropathy in the bilateral lower extremities, and findings suggestive of chronic bilateral L5/S1 radiculopathy. Conservative treatment included acupuncture, right sacroiliac joint injection, epidural steroid injection, pain medication, muscle relaxant, and chiropractic treatment without sustained relief. The 3/19/14 treating physician report cited right lower extremity hip and knee pain. She had about 5 days of relief in symptoms with a right sacroiliac joint injection on 1/14/14. Physical exam documented tenderness to palpation over the right sacroiliac joint, greater trochanter, and patella. Faber's test was positive on the right. Lower extremity neurologic exam documented normal strength, sensation, and deep tendon reflexes. A right greater trochanteric bursa steroid injection was provided. The treatment plan recommended chiropractic treatment 2x6 and continued medication. Work restrictions were outlined. The 2/13/15 utilization review non-certified the request for L4/5 posterior spinal fusion with transforaminal lumbar interbody fusion as the injured worker's clinical findings did not correlate with the reported imaging findings or the

EMG on 12/9/13, and there was no discussion regarding the potential for temporary intraoperative instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 Posterior Spinal Fusion with Transforaminal Lumbar Interbody Fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS 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) 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. Guidelines state that spinal fusion is recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise. 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. The patient presents with imaging findings of multilevel significant lumbar degenerative disc disease, canal and severe foraminal stenosis and electrodiagnostic evidence consistent with bilateral L5/S1 radiculopathy. There is also evidence of grade 1 anterolisthesis at L4/5 and L5/S1. However, there is no submitted imaging documentation of spinal segmental instability or discussion of potential need for wide decompression that would result in temporary intra-operative instability requiring fusion. There is no current documentation of a focal neurologic deficit on clinical exam. There is no evidence of psychosocial screening. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Post-Operative Chiropractic (12-sessions, 2 times a week for 6 weeks for the lumbar spine, to begin at 4 months post-op): 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.

Pre-Operative Medical Clearance (including medical consult for history and physical, EKG, chest x-ray and labs): 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.