

Case Number:	CM15-0052421		
Date Assigned:	03/25/2015	Date of Injury:	08/25/2008
Decision Date:	05/13/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/19/2015

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: 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 48-year-old male who reported injury on 08/25/2008. His mechanism of injury was stepping in a pothole while responding to an alarm while at work. His diagnoses include lumbar disc degeneration with chronic low back pain, bilateral postoperative L4 radiculopathy, L4 foraminal stenosis bilaterally, chronic intractable pain. Past treatments have included physical therapy, nerve root blocks, SI joint radiofrequency ablation, and work modification. Diagnostic studies included a CT scan of the lumbar spine performed on 11/21/2013 with results indicating no significant interval change since prior CT scan from 06/03/2013. Postoperative changes at L4-5 and L5-S1 compatible with interbody fusion, with mostly stable postoperative appearance. Mild to moderate foraminal narrowing at L4-5 again noted. Urine drug screen performed on 01/21/2014 that was positive for benzodiazepines and oxycodone. General toxicology report on 01/24/2014. Urine drug screen on 04/22/2014. X-ray of the lumbar spine performed on 06/09/2014 with indications of anterior and posterior fusion of L4-S1 appear solid. No hardware loosening or fractures. A CT of the lumbar spine on 07/16/2014 with indications of lumbar laminectomy and fusion with normal lumbar vertebral alignment in the current study. Postop scar tissue type changes within the central L4-5 and L5-S1 region in the perithecal region, extension into the foraminal sites as well. His surgical history included posterior spinal fusion at L4-5 and L5-S1 using autograft, and iliac crest bone graft through separate incision from STEM cells performed on 03/13/2013. A right L4, L5, S1 and left L4, L5, S1 selective nerve root blocks performed on 07/14/2014 with a lumbar epidurogram. On 01/05/2015, an SI joint radiofrequency ablation was performed. The injured worker had

complaints of lower back pain with numbness and tingling radiating down bilateral lower extremities which he rates at a 5/10. Bilateral shoulder pain that he rates a 5/10. On physical exam, it was noted sensation was decreased over the right L4 dermatome distribution. Absent reflexes, bilateral knees, and right ankle. His medications included oxycodone 20 mg, docusate 100 mg, Prilosec 20 mg, gabapentin 300 mg, Zanaflex 4 mg, Ambien 10 mg, and Valium 5 mg. The rationale for the request was not included in the medical records. The Request for Authorization form is signed and dated 02/02/2015 in the medical records. The treatment plan included request for bilateral L4 foraminotomy/osteotomy/sacroiliac joint fusions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4 Foraminotomy/Osteotomy/Sacroiliac joint fusions: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Discectomy/ laminectomy.

Decision rationale: The Official Disability Guidelines state required symptoms/findings must include imaging studies; & conservative treatments L4 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy. 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness. 3. Unilateral hip/thigh/knee/medial pain. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings: A. Nerve root compression (L3, L4, L5, or S1). B. Lateral disc rupture. C. Lateral recess stenosis. Diagnostic imaging modalities, requiring ONE of the following: 1. MR imaging. 2. CT scanning. 3. Myelography. 4. CT myelography & X-Ray. Conservative Treatments, requiring ALL of the following: A. Activity modification (not bed rest) after patient education (\geq 2 months). B. Drug therapy, requiring at least ONE of the following: 1. NSAID drug therapy. 2. Other analgesic therapy. 3. Muscle relaxants. 4. Epidural Steroid Injection (ESI). C. Support provider referral, requiring at least ONE of the following (in order of priority): 1. Physical therapy (teach home exercise/stretching). 2. Manual therapy (chiropractor or massage therapist). 3. Psychological screening that could affect surgical outcome. 4. Back school. There is a lack of documentation regarding effectiveness of nerve root blocks, effectiveness of radiofrequency ablation, and recent physical therapy. Therefore, the request for bilateral L4 foraminotomy/osteotomy/sacroiliac joint fusions, is not medically necessary.

Medical Pre-op clearance: Upheld

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

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: Lumbar LSO: Upheld

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

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: Assistant Surgeon: Upheld

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

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: Inpatient stay (days) Qty: 1.00: Upheld

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

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: Pneumatic Intermittent compression device: Upheld

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

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.

Post-op physical therapy Qty: 18.00: Upheld

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

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.