

Case Number:	CM15-0081324		
Date Assigned:	05/04/2015	Date of Injury:	03/02/2008
Decision Date:	06/03/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/28/2015

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: New York
 Certification(s)/Specialty: 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 sustained an industrial injury on March 2, 2008. He has reported lower back injury and has been diagnosed with sprain/strain of the lumbar spine, left L5-S1 radiculopathy. Treatment has included medical imaging, injections, rest, ice, heat, medications, and chiropractic care. Progress report dated March 12, 2013 noted increased symptomology to the lower back radiating down into his left lower extremity. The treatment request included surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

L1-L2 and L2-L3 XLIF (eXtreme Lateral Interbody Fusion): Upheld

Claims Administrator 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 Procedure, XLIF (eXtreme Lateral Interbody Fusion).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-307.

Decision rationale: The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The provider states the patient's images proves instability but does not include radiological interpretations showing movement. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation provides no evidence to corroborate a L1, L2 or L3 nerve root involvement as a pain generator. The guidelines note the patient would have failed a trial of conservative therapy. Details of such a trial are not included. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: L1-L2 and L2-L3 XLIF (eXtreme Lateral Interbody Fusion) is NOT Medically necessary and appropriate.

Left L2-L3 laminectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure, Indications for Surgery - Discectomy/laminectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-307.

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation is not provided to objectively show the L2, L3 nerve roots are this patient's pain generators. The guidelines note the patient would have failed a trial of conservative therapy. Documentation does not provide details of such a trial's failure. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: Left L2-L3 laminectomy is NOT Medically necessary and appropriate.

Left L2-L3 microdiscectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure, Indications for Surgery - Discectomy/laminectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-307.

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation is not provided to objectively show the L2, L3 nerve roots are this

patient's pain generators. The guidelines note the patient would have failed a trial of conservative therapy. Documentation does not provide details of such a trial's failure. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: Left L2-L3 microdisectomy is NOT Medically necessary and appropriate.

Assistant surgeon/PA: 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.