

Case Number:	CM14-0121058		
Date Assigned:	10/01/2014	Date of Injury:	11/01/2011
Decision Date:	10/30/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/31/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 37-year-old female with a 11/1/11 date of injury, and TLIF/PSF in July of 2013. At the time (6/30/14) of the Decision for Spinal Cord Stimulator, Revision Decompression, Decompression, additional levels times two (2), Spinal fusion, Fusion, additional levels times two (2), Reinstrumentation, and Moss Cage, there is documentation of subjective (throbbing, burning, tingling, pins, and needles pain) and objective (positive straight leg raise bilaterally, focal sensory deficit, and focal motor deficit) findings, current diagnoses (post-laminectomy syndrome lumbar region (L4-5)), and treatment to date (physical therapy, TENS unit, spinal cord stimulation with 70% pain relief and functional benefit, and medications). Regarding decompression and fusion, there is no specific (to a nerve root distribution) documentation of subjective and objective radicular findings in the requested nerve root distributions, imaging report at the requested levels, and an Indication for fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal Cord Stimulator: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Spinal Cord Stimulator

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines spinal cord stimulators (SCS) Page(s): 105-107.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that SCS is recommended as a treatment option for adults with chronic neuropathic pain lasting at least 6 months despite appropriate conventional medical management, and who have had a successful trial of stimulation, as criteria necessary to support the medical necessity of permanent spinal cord stimulation. ODG identifies documentation of 50% pain relief and medication reduction or functional improvement after temporary trial, as criteria necessary to support the medical necessity of permanent spinal cord stimulation. Within the medical information available for review, there is documentation of a diagnosis of post-laminectomy syndrome lumbar region. In addition, there is documentation of a previous spinal cord stimulation trial with 70% pain relief and functional improvement after temporary trial. Therefore, based on guidelines and a review of the evidence, the request for Spinal Cord Stimulator is medically necessary.

Revision Decompression:

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), Indications for Surgery, Discectomy/laminectomy

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 Chapter, Discectomy/laminectomy

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, and an Indication for fusion (instability OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminotomy/fusion. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities), as criteria necessary to support the medical necessity of decompression. Within the medical information available for review, there is documentation of a diagnosis of post-laminectomy syndrome lumbar region (L4-5). In addition, there is documentation of failure of conservative treatment (activity modification, medications, and physical modalities). However, despite non-specific documentation of subjective (throbbing, burning, tingling, pins, and needles pain) and objective (positive straight leg raise bilaterally, focal sensory deficit, and focal motor deficit) findings, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness, or tingling) and objective (sensory changes, motor changes, or reflex

changes) radicular findings in the requested nerve root distributions. In addition, there is no documentation of an imaging report with findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested levels. Furthermore, there is no documentation of an Indication for fusion (instability OR a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for Revision Decompression is not medically necessary.

Decompression, additional levels times two (2): 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), Indications for Surgery, Discectomy/laminectomy

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 Chapter, Discectomy/laminectomy

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, and an Indication for fusion (instability OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminotomy/fusion. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities), as criteria necessary to support the medical necessity of decompression. Within the medical information available for review, there is documentation of a diagnosis of post-laminectomy syndrome lumbar region (L4-5). In addition, there is documentation of failure of conservative treatment (activity modification, medications, and physical modalities). However, despite non-specific documentation of subjective (throbbing, burning, tingling, pins, and needles pain) and objective (positive straight leg raise bilaterally, focal sensory deficit, and focal motor deficit) findings, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness, or tingling) and objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distributions. In addition, there is no documentation of an imaging report with findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested levels. Furthermore, there is no documentation of an Indication for fusion (instability OR a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for Decompression, additional levels times two (2) is not medically necessary.

Spinal fusion: 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), Indications for Surgery, Discectomy/laminectomy

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 Chapter, Discectomy/laminectomy

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, and an Indication for fusion (instability OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminotomy/fusion. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities), as criteria necessary to support the medical necessity of decompression. Within the medical information available for review, there is documentation of a diagnosis of post-laminectomy syndrome lumbar region (L4-5). In addition, there is documentation of failure of conservative treatment (activity modification, medications, and physical modalities). However, despite non-specific documentation of subjective (throbbing, burning, tingling, pins, and needles pain) and objective (positive straight leg raise bilaterally, focal sensory deficit, and focal motor deficit) findings, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness, or tingling) and objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distributions. In addition, there is no documentation of an imaging report with findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested levels. Furthermore, there is no documentation of an Indication for fusion (instability OR a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for Spinal fusion is not medically necessary.

Fusion, additional levels times two (2): 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), Indications for Surgery, Discectomy/laminectomy

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 Chapter, Discectomy/laminectomy

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, and an Indication for fusion (instability OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminotomy/fusion. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities), as criteria necessary to support the medical necessity of decompression. Within the medical information available for review, there is documentation of a diagnosis of post-laminectomy syndrome lumbar region (L4-5). In addition, there is documentation of failure of conservative treatment (activity modification, medications, and physical modalities). However, despite non-specific documentation of subjective (throbbing, burning, tingling, pins, and needles pain) and objective (positive straight leg raise bilaterally, focal sensory deficit, and focal motor deficit) findings, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness, or tingling) and objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distributions. In addition, there is no documentation of an imaging report with findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested levels. Furthermore, there is no documentation of an Indication for fusion (instability OR a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for Fusion, additional levels times two (2) is not medically necessary.

Reinstrumentation:

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: There is no documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for Reinstrumentation is not medically necessary.

Moss Cage: 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: There is no documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for Moss Cage is not medically necessary.