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| Case Number: | CM14-0180882 | | |
| Date Assigned: | 11/06/2014 | Date of Injury: | 11/14/1986 |
| Decision Date: | 12/15/2014 | UR Denial Date: | 10/20/2014 |
| Priority: | Standard | Application Received: | 10/30/2014 |

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 Orthopedic Surgery 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:

64 year old female claimant with an industrial injury dated 11/14/86. CT scan dated 06/25/14 reveals severe diffuse canal stenosis at L4-5 level as described with degenerative listhesis of L4 on L5. There is also a bulging disc with bulging projecting into the foraminal site with mild foraminal encroachment on the left at L5-S1 level. Exam note 08/22/14 states the patient returns with low back pain. The patient explains that the pain is predominantly over the left lower extremity with numbness and weakness. The patient rates the pain a 9/10 and the distal pain a 6/10. The pain is noted to be constantly worsening and there is significant radiculopathy in the left lower extremity. Medications include Fentanyl patch, Oxycontin, and Oxycodone. The patient has difficulty with prolonged walking, and cannot achieve a neutral posture. The patient completed a positive straight leg raise test. The patient had decreased sensation in L5 and S1 on the left. Diagnosis is noted as spinal stenosis without neurogenic claudication, displacement of lumbar intervertebral disc without myelopathy, and acquired spondylolisthesis. Treatment includes an anterior and posterior fusion at L4-S1 with decompression at L4-5. Sacroiliac joint fusion requested on the left side.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left SI Joint Fusion: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Sacroiliac joint fusion

Decision rationale: CA MTUS/ACOEM is silent on the issue of sacroiliac joint fusion. According to the ODG, Low Back section, Sacroiliac joint fusion, "not recommended except as a last resort for chronic or severe sacroiliac joint pain." In this case there is lack of demonstration in the records from 8/22/14 of severe sacroiliac joint destruction or dysfunction to warrant a sacroiliac joint fusion. Therefore the determination is for non-certification.

Co-Surgeon and Assistant Surgeon: 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.

5 Days In-Patient: 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-Op Cardiac Clearance: 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.

Anterior Fusion L4-S1 Decompression L4-5, Post Fusion L4-S1, Instrumentation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS 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, Fusion (spinal)

Decision rationale: The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm or psychiatric clearance to warrant fusion. In addition there is lack of proper documentation of failed nonsurgical management. Therefore the determination is non-certification for lumbar fusion.