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| Case Number: | CM14-0201364 | | |
| Date Assigned: | 12/11/2014 | Date of Injury: | 11/01/2012 |
| Decision Date: | 02/09/2015 | UR Denial Date: | 11/21/2014 |
| Priority: | Standard | Application Received: | 12/02/2014 |

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 Minnesota. 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:

The injured worker is a 46-year-old male with a history of a traumatic fall from a crane at a construction site on 11/1/2012. The current request pertains to L5-S1 decompression/fusion with instrumentation. Pain management notes dated December 3, 2013 document low back pain with radiation down the right lower extremity to the ankle/foot. X-rays revealed a stable L2 compression fracture without subluxation. There was decreased disc height at L5-S1. Per available documentation, the fall also resulted in a fracture of the coccyx that was reduced in the emergency room. X-rays of the sacrum and coccyx dated April 3, 2014 revealed no acute abnormality or change since the prior films. Alignment was normal. The injured worker complained of chronic neck pain and had evidence of spinal stenosis and disc herniations from C4-C7. He underwent anterior cervical discectomy and fusion at C4-5, C5-6, and C6-7 on 5/5/2014. Per orthopedic notes of 11/19/2014 he was complaining of constant debilitating low back pain radiating down the right leg. He was walking with a cane at all times. Lumbar decompression and interbody instrumented fusion at L5-S1 level was advised. The radiology report pertaining to the MRI scan of the lumbar spine dated 11/4/2014 is noted. The report indicates no change since the prior CT scan of 8/26/2013. At L5-S1 there was a small to moderate-sized central disc osteophyte complex and mild facet degeneration. The disc osteophyte complex mildly impressed upon the ventral thecal sac and resulted in moderate spinal stenosis. There was narrowing of the subarticular recesses but no gross compression of the traversing nerve root sheaths was identified. There was also moderate bilateral foraminal narrowing, right more than left, similar to the previous exam. The request for L5-S1 lumbar decompression with instrumentation and interbody fusion, and intraoperative spinal cord monitoring was non-certified by utilization review on 11/21/2014. X-rays of the lumbar spine did not reveal any evidence of instability and/or motion. Without instability or motion on the x-

rays, treatment guidelines do not recommend a spinal stabilization/fusion. Furthermore, there had not been a proven pain generator. Additionally, the injured worker continued to have significant psychiatric problems. Therefore surgery was not indicated. The denial has now been appealed to an independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 lumbar decompression with instrumentation and interbody fusion, intraoperative spinal cord monitoring: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 310, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Low back chapter, criteria for lumbar spinal fusion

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307, 310.

Decision rationale: California MTUS guidelines do not recommend spinal fusion in the absence of fracture, dislocation, complications of tumor or infection. Patient's with increased spinal instability after surgical decompression at the level of the degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials the spinal fusion alone is effective for treating any type of acute low back problem in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. The documentation does not indicate any instability at the L5-S1 level. The last MRI scan did not show any evidence of nerve root compression. Based on the above guidelines, the request for L5-S1 lumbar decompression with instrumentation and interbody fusion and intraoperative spinal cord monitoring is not supported and as such, the medical necessity of the request is not substantiated.

Inpatient hospitalization x2 days for lumbar spine surgery: 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.

Assistant surgeon for lumbar spine surgery: 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.