MAXIMUS Federal Services

Case Number:	CM14-0216552		
Date Assigned:	01/06/2015	Date of Injury:	10/01/2008
Decision Date:	03/12/2015	UR Denial Date:	12/15/2014
Priority:	Standard	Application Received:	12/26/2014

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. 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: Minnesota, Florida
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 44 year old female who sustained a work related injury October 1, 2008. Past history included non-industrial kidney stones with urinary tract infections, JJ stent placement with subsequent removal, diet controlled diabetes, and reactive depression, stable with Latuda, Zoloft and hydroxyzine for anxiety. According to a neurosurgical re-evaluation, dated December 3, 2014, the injured worker presents with discogenic low back pain and radiculopathy. She had a positive diskogram on 6/23/2011 which was positive at L5-S1 and L4-5. A new MRI dated 3/29/2014 (present in medical record) shows L4-5 with moderate disk disease and a disk bulge with bilateral nerve root compression. L5-S1 has moderate degenerative disk disease with a disk bulge and bilateral arthropathy. Treatment plan included request for surgery, length of stay, assistant surgeon, pre-op clearance, bone growth stimulator, and TLSO brace. Work status is documented as temporarily totally disabled through 12/30/2014. According to utilization review performed December 15, 2014, the request for L4-5 and L5-S1 Anterior Lumbar Interbody Fusion with LDR Anterior Instrumentation and Posterior Augmentation with an Aspen like device and citing official Disability Guidelines (ODG) Low Back Fusion is not medically necessary and reasonable at this time. As such, the request is non-certified. Regarding the request for an Assistant Surgeon; TLSO Brace; Preoperative Medical Clearance; Bone Growth Stimulator; In-patient Length of Stay (unknown) and citing Official Disability Guidelines (ODG) Low Back Fusion-all the requests are non-certified as the requested surgery is not medically necessary and reasonable at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 and L5-S1 anterior lumbar interbody fusion with LDR anterior instrumentation and posterior augmentation with an aspen like device: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: The injured worker has chronic low back pain. MRI scan of the lumbosacral spine dated 3/29/2014 revealed degenerative disc disease at L4-5 and L5-S1. There was an annular tear at L5-S1 with a 3-4 mm midline and right paracentral disc protrusion indenting the thecal sac and slightly displacing the exiting L5 nerve roots bilaterally. Facet arthropathy was noted with mild to moderate right foraminal stenosis. At L5-S1 the disc height was diminished with associated desiccation. There was a broad-based 3-4 mm disc protrusion. There was no associated nerve impingement or canal stenosis. Lateral annular bulging and facet arthropathy caused moderate foraminal stenosis. The California MTUS guidelines indicate that patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. Such is not the case here. There is no instability documented. Per guidelines, 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 that spinal fusion alone is effective for treating low back pain, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as much better in the surgical group versus 14% much better in the non-fusion group, a 15% greater chance of being much better versus a 17% complication rate. In table 12?8 on page 310 the guidelines indicate that spinal fusion is not recommended in the absence of fracture, dislocation, complications of tumor, or infection. The documentation does not indicate a recent comprehensive non-surgical treatment program with failure. As such, the request for an L4-L5 and L5-S1 anterior lumbar interbody fusion with LDR anterior instrumentation and posterior augmentation is not supported by guidelines and the medical necessity is not substantiated.

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.

Associated surgical service: TLSO brace: 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.

Associated surgical service: Preoperative medical 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.

Associated surgical service: Bone growth stimulator: 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.

Inpatient LOS unknown: 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.