

Case Number:	CM14-0217946		
Date Assigned:	01/07/2015	Date of Injury:	03/19/1997
Decision Date:	03/20/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	12/29/2014

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:

This 50 year old male sustained a work related injury on 3/19/1997. The mechanism of injury was reported to be injury from falling out of a truck and landing on the curb. The current diagnoses are spondylosis and stenosis at L1-L2 and L2-L3 with radiculopathy. According to the progress report dated 12/4/2014, the injured workers chief complaints were increasing low back pain with sciatica. The pain is aggravated by even minimal activities of daily living. The physical examination of the lumbar spine revealed marked tenderness to palpation. There is severely restricted range of motion in all directions. Straight leg raise test is positive bilaterally at 30 degrees in the seated position reproducing sciatica. There is mild weakness of the iliopsoas and quadriceps muscles bilaterally, greater on the right. Deep tendon reflexes are hypoactive throughout. There are no pathological reflexes. There is diminished sensation over the anterior thigh bilaterally. Current medications are Oxycontin, Morphine, Celebrex, and Lyrica. On this date, the treating physician prescribed bilateral decompressive laminectomy at L1-L2 with foraminotomy for decompression of the spinal canal and nerve roots, removal of implanted pedicle screws at L2-L3, new instrumentation at L1-L3 with bilateral posterolateral fusion, interbody fusion with cages by the posterior at L1-L2, associated surgical service: inpatient hospital stay (3 days), assistant surgeon, pre-op labs, pre-op EKG, history and physical, EMG of the bilateral lower extremities, TLSO back brace, and repeat laminectomy foraminotomy at the L2-L3 level, which is now under review. When the surgery was first prescribed work status was not described. On 12/18/2014, Utilization Review had non-certified a prescription for bilateral decompressive laminectomy at L1-L2 with foraminotomy for decompression of the spinal canal

and nerve roots, removal of implanted pedicle screws at L2-L3, new instrumentation at L1-L3 with bilateral posterolateral fusion, interbody fusion with cages by the posterior at L1-L2, associated surgical services: inpatient hospital stay (3 days), assistant surgeon, pre-op labs, pre-op EKG, history and physical, EMG of the bilateral lower extremities, TLSO back brace, and repeat laminectomy foraminotomy at the L2-L3 level. The surgery was non-certified based on lack of documentation of an exhaustion of recent conservative care. The California MTUS ACOEM Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral decompressive laminectomy at L1-L2 with foraminotomy for decompression of the spinal canal and nerve roots: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 306, 307.

Decision rationale: The CT scan of the lumbar spine without contrast dated 10/13/2014 is noted. The report indicates postsurgical changes of lumbar spine with evidence of lower lumbar laminectomy with interbody spacers at L2-3, L3-4, and L4-5 and posterior fusion hardware at L2-3. Hardware appears stable from previous exam. No hardware fracture or evidence for hardware loosening. Fixation screws at the level of the sacroiliac joints are new from prior exam. This hardware is intact. There is slight anterolisthesis of L2 on L3, unchanged. Bilateral facet arthropathy is unchanged from prior exam. Broad disc osteophyte complex and facet arthropathy at L1-2 results in moderate bilateral neural foraminal stenosis and mild to moderate central canal stenosis. The guidelines require clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. The spinal stenosis is known to benefit from decompressive laminectomies. However, the radiology report indicates that the spinal stenosis is mild to moderate. The foraminotomies necessitate evidence of nerve root compression. The imaging study does not show a definite evidence of nerve root compression. Therefore electrophysiologic evidence is also recommended. The available documentation does not include electrodiagnostic studies. Epidural steroid injections have not been tried and relief/failure has not been documented. As such, the evidence supporting the need for decompressive laminectomies and foraminotomy is not complete and does not meet the guideline requirement of clear clinical, electrophysiologic, and imaging evidence of a lesion that is known to benefit from surgical repair. The guideline requirements are therefore partially met. As such, the request for decompressive laminectomies and foraminotomy at L1-2 is partially supported and the medical necessity is not established.

Removal of implanted pedicle screws at L2-L3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Hardware implant removal (fixation)

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

Decision rationale: The removal of the pedicle screws at L2-3 is requested to include L1-2 in the fusion. There is no documented instability at L1-2 and there is no spondylolisthesis at that level. The California MTUS guidelines on page 310 do not recommend a spinal fusion in the absence of fracture, dislocation, complications of tumor or infection. As such, the guidelines do not support a fusion at L1-2 and the medical necessity of removal of the pedicle screws at L2-3 to extend the fusion to L1-2 is not substantiated.

New instrumentation at L1-L3 with bilateral posterolateral fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): (s) 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Fusion (spinal)

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

Decision rationale: With regard to spinal fusion, the guidelines are very specific as far as the indications. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, spondylolisthesis if there is instability and motion in the segment operated on. Lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study showed that 29% of patients 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 17% complication rate. On page 310 the guidelines conclude that spinal fusion is not recommended in the absence of fracture, dislocation, complications of tumor, or infection. There is no instability documented at L1-2. The slight anterolisthesis is at L2-3 and there has been a fusion performed at that level. As such, the request for a fusion at L1-2 is not supported and the medical necessity is not established.

Interbody fusion with cages by the posterior at L1-L2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): (s) 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Fusion (spinal)

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

Decision rationale: With regard to spinal fusion, the California MTUS guidelines are very specific as far as the indications. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, spondylolisthesis if there is instability and motion in the segment operated on. Lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study showed that 29% of patients 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 17% complication rate. On page 310 the guidelines conclude that spinal fusion is not recommended in the absence of fracture, dislocation, complications of tumor, or infection. There is no instability documented at L1-2. The slight anterolisthesis is at L2-3 and there has been a fusion performed at that level. There has been no pain relief from the extensive fusion at other levels. In light of the above the request for the fusion at L1-2 is not supported by guidelines and the medical necessity is not substantiated.

Associated surgical service: inpatient hospital stay, 3 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Hospital length of stay (LOS)

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: assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Surgical assistant

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: pre-op lab: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Preoperative lab testing

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: pre-op EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Preoperative electrocardiogram (ECG)

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: history and physical: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Office visit

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: EMG of the bilateral lower extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 305.

Decision rationale: Electrodiagnostic studies are recommended to confirm the level of radiculopathy prior to the foraminotomy and decompression. As such the request is supported by guidelines which require electrodiagnostic corroboration of the clinical and imaging findings and the medical necessity is established. Therefore the request is medically necessary.

Associated surgical service: thoracic lumbar sacral orthosis (TLSO) back brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Back brace, postoperative (fusion)

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.

Repeat laminectomy foraminotomy at the L2-L3 level: 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): 305, 306.

Decision rationale: The CT scan did not show any change at L2-3 compared to the prior study. There is no electrophysiologic evidence of radiculopathy at that level. There is a fusion performed at that level. In the absence of clear clinical, imaging or electrophysiologic evidence of nerve root compression at that level, a repeat laminectomy and foraminotomy is not supported by guidelines and the medical necessity is not established.