

Case Number:	CM15-0002727		
Date Assigned:	02/12/2015	Date of Injury:	02/26/1997
Decision Date:	03/30/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	01/06/2015

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: Illinois, California, Texas
 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 79-year-old male who sustained an industrial injury on 02/26/97. He underwent bilateral sacroiliac (SI) joint fusion on 7/31/14 with a subsequent evacuation of a right gluteal post-op hematoma and ligation of the gluteal artery the same day. The 9/25/14 lumbar spine MRI documented a grade 1 retrolisthesis at L4/5 with moderate canal stenosis, moderate bilateral neuroforaminal narrowing, and a 4 mm right disc protrusion impinging on the right descending L5 nerve root. At L5/S1, there was mild bilateral neuroforaminal narrowing. The 9/30/14 x-rays documented grade 1 retrolisthesis at L4/5 with no evidence of instability. The 12/1/14 treating physician report indicated the injured worker's buttocks pain had improved following SI joint fusion. He presented with moderate mid to low back pain radiating to the bilateral buttocks and into both hips, down the left anterior and posterior thigh and through the shin and calf. He had signs of neurogenic claudication. Physical exam documented a slight limp favoring the right, moderate to marked loss of lumbar range of motion, and tenderness to palpation over L4/5 and L5/S1. Sensation was decreased over the right L4, L5, and S1 dermatomes. Right patellar reflex and bilateral Achilles reflexes were absent. Right hip flexion and extensor hallucis longus weakness was documented. Authorization was requested for L4/5 bilateral laminotomies and posterior spinal stabilization and fusion, with associated lumbosacral brace, pneumatic compression device, front wheeled walker, cold therapy unit, assistant surgeon, inpatient stay, postoperative physical therapy, preoperative clearance and chest x-ray. On 12/18/14, utilization review non-certified the L4/5 bilateral laminotomies and posterior spinal

stabilization and fusion, citing MTUS guidelines. As the surgery was non-certified, all associated services were also non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 right laminotomy and posterior spinal stabilization and 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), Low Back, Lumbar & Thoracic (Acute & Chronic) 2014, Fusion

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307. Decision based on Non-MTUS Citation Low Back Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal)

Decision rationale: The California MTUS guidelines recommend lumbar discectomy for carefully selected patients with nerve root compression due to lumbar disc prolapse. MTUS guidelines indicate that lumbar spinal fusion may be considered for patient with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. The Official Disability Guidelines recommend criteria for lumbar laminotomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. This patient presents with symptoms of neurogenic claudication. Clinical exam findings are consistent with imaging evidence of neural compression. There is no radiographic evidence of spinal segmental instability. Psychosocial evaluation is not evidenced. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

L4-L5 left laminotomy and posterior spinal stabilization and 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), Low Back, Lumbar & Thoracic (Acute & Chronic) 2014, Fusion

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

Decision rationale: The California MTUS guidelines recommend lumbar discectomy for carefully selected patients with nerve root compression due to lumbar disc prolapse. MTUS

guidelines indicate that lumbar spinal fusion may be considered for patient with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. The Official Disability Guidelines recommend criteria for lumbar laminotomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. This patient presents with symptoms of neurogenic claudication. Clinical exam findings are consistent with imaging evidence of neural compression. There is no radiographic evidence of spinal segmental instability. Psychosocial evaluation is not evidenced. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Associated surgical service: LSO Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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: Pneumatic intermittent compression 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 (ODG), Knee & Leg (Acute & Chronic), AAOS/ACCP, 2010

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: Front wheeled walker: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

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: Cold therapy unit - 30 day: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic)

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.

Post-op physiotherapy to low back QTY: 18.00: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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 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: Chest x-ray: 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, Lumbar & Thoracic (Acute & Chronic) Fusion

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back Lumbar & Thoracic: Preoperative testing, general

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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, Lumbar & Thoracic (Acute & Chronic)

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: 1 inpatient facility day: 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, Lumbar & Thoracic (Acute & Chronic)

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.