

Case Number:	CM15-0173756		
Date Assigned:	09/15/2015	Date of Injury:	04/16/2011
Decision Date:	11/12/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/03/2015

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: New York, Montana
 Certification(s)/Specialty: Neurological 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 47-year-old female, who sustained an industrial injury on 4-6-11. Medical record indicated the injured worker is undergoing treatment for thoracic lumbosacral neuritis, spinal stenosis of lumbar spine with neurogenic claudication and intervertebral disc disease with myelopathy of lumbar spine. Treatment to date has included injections, oral medications including Medrol dose pack 4mg, Naproxen 550mg, Prilosec 20mg, Fexmid, Zofran, Norco and Tramadol; physical therapy (which proved helpful and decreased the pain), home exercise program and activity modifications. (MRI) magnetic resonance imaging of lumbar spine performed on 1-16-15 noted multilevel degenerative disc disease, multilevel joint facet osteoarthritis and partially imaged left adnexal lesions. Currently on 8-5-15, the injured worker reports temporary relief of radicular pain with injection and left leg weakness and neck and trapezial pain that does not go past shoulders. Physical exam performed on 8-5-15 revealed inspection and palpation of lumbar spine within normal limits, muscle testing within normal limits, patella reflexes asymmetrical, decreased bilateral reflexes of Achilles and sensation was normal with the exception of bilateral thigh numbness. On 8-24-15, a request for authorization was submitted for L4-5 and L5-S1 anterior discectomy and fusion and L4-S1 posterior instrumented fusion, 3-day inpatient stay, co-surgeon, lumbar brace, Orthofix bone growth stimulator and front wheel walker and a 3 in 1 commode. On 8-28-15, utilization review non-certified a request for lumbar anterior discectomy, fusion and posterior instrumentation noting previous physical therapy decreased the pain; there are no reports of recent physical therapy and there is no documentation of any recent positive orthopedic tests; proceeding with surgical

treatment does not appear medically necessary at this time and 3-day inpatient stay, co-surgeon, lumbar brace, Orthofix bone growth stimulator and front wheel walker and a 3 in 1 commode are not recommended as the surgery is not certified at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Discectomy and Fusion at L4-5, L5-S1 and Posterior Instrumented Fusion at L4-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: The California MTUS guidelines recommend lumbar surgery if there are severe persistent, debilitating lower extremity complaints, clear clinical and imaging evidence of a specific lesion corresponding to a nerve root or spinal cord level, corroborated by electrophysiological studies, which is known to respond to surgical repair both in the near and long term. Documentation does not provide this evidence. His magnetic resonance imaging scan (MRI) shows no severe canal or foraminal stenosis or nerve root impingement. His provider recommended an anterior discectomy L4-5 and L5-S1 with lumbar arthrodesis and posterior instrumented fusion L4-S1 to treat his lumbago. Documentation does not present evidence of instability or radiculopathy. According to the Guidelines for the performance of fusion procedures for degenerative diseases of the lumbar spine, published by the joint section of the American Association of Neurological surgeons and Congress of Neurological surgeons in 2005 there was no convincing medical evidence to support the routine use of lumbar fusion at the time of primary lumbar disc excision. This recommendation was not changed in the update of 2014. The update did note that fusion might be an option if there is evidence of spinal instability, chronic low back pain and severe degenerative changes. The California MTUS guidelines do recommend spinal fusion if there is fracture, dislocation or instability. Documentation does not show instability or severe degenerative changes. The documentation does not support that the Requested Treatment: Anterior Discectomy and Fusion at L4-5, L5-S1 and Posterior Instrumented Fusion at L4-S1 is medically necessary and appropriate.

Associated Surgical Service: 3 Day Inpatient Stay: 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: Co-Surgeon with Treating Physician: 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: Lumbar 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: Orthofix 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.

Associated Surgical Service: Front Wheeled Walker: 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: 3 in 1 Commode: 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.