

Case Number:	CM15-0176114		
Date Assigned:	09/18/2015	Date of Injury:	02/28/2015
Decision Date:	11/03/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/08/2015

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 70-year-old female, who sustained an industrial-work injury on 2-28-15. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar disc displacement, grade 1 spondylolysis L3-4 and L4-5, and spinal stenosis. Medical records dated (5-4-15 to 8-19-15) indicate that the injured worker complains of pain in the low back pain with pain that radiates down the right leg in to the foot. There is numbness, weakness in the right leg, there is pain in the right hip, the pain increases with walking, and she uses a walker for ambulation. The pain was rated 9 out of 10 on pain scale and had been 10 out of 10. The medical records also indicate worsening of the activities of daily living. Per the treating physician, report dated 8-19-15 the injured worker has not returned to work. The physical exam dated 8-19-15 reveals that she uses a walker for ambulation. She is unable to stand without significant difficulty and there is marked decreased range of motion of the lumbar spine. The L4- L5 sensory exam reveals that there is decreased sensation. The gait is antalgic. The physician indicates that her symptoms increase with all activities and she has failed over six months of non-operative care. He recommends that surgical intervention is indicated and warranted. Treatment to date has included pain medication, diagnostics, acupuncture, physical therapy (unknown amount), epidural steroid injection (ESI) 8-5-15 with no relief, off work, activity modifications, walker, and other modalities. Magnetic resonance imaging (MRI) of the lumbar spine dated 4-29-15 reveals grade 1 degenerative anterolisthesis (2 mm) of L4 on L5 and no significant central canal or neural foraminal narrowing. The medical record dated 8-19-15 the physician indicates that x-rays that were done 8-19-15 of the lumbar spine reveal grade 1

spondylolisthesis L3-4 and L4-5 with motion of over 5-millimeters noted on lateral flexion and extension studies at both levels. Radiologist's report substantiating this assertion is not found in the documentation. The request for authorization date was 8-21-15 and requested services included Anterior Lumbar Discectomy and Fusion (ALDF) L3-4, L4-5 with allograft, cage, plate, Associated Surgical Service: Hot-cold Therapy Unit, Associated Surgical Service: Bone Growth Stimulator, and Associated Surgical Service: Muscle Stimulator. The original Utilization review dated 8-28-15 modified the request for Anterior Lumbar Discectomy and Fusion (ALDF) L3-4, L4-5 with allograft, cage, plate, modified to Anterior Lumbar Discectomy and Fusion (ALDF) L4-5 with allograft, cage, plate, as the Magnetic Resonance Imaging (MRI) does not show canal or foraminal narrowing at L3 and L4 and therefore does not meet guidelines for fusion. The requests for Associated Surgical Service: Hot-cold Therapy Unit, Associated Surgical Service: Bone Growth Stimulator, and Associated Surgical Service: Muscle Stimulator were non certified as studies show that the hot-ice machine does not offer any benefit over standard cryotherapy with ice packs and there are no studies to evaluate its use as a heat source. Regarding the bone growth stimulator, the guidelines do not provide specific evidence around the request directly related to the treatment being requested for the injured worker with limited evidence of improving the fusion rate in spinal surgery in high-risk cases. Regarding the muscle stimulator, the physician withdrew the request in his phone conversation with the physician reviewer.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Lumbar Discectomy and Fusion (ALDF) L3-4, L4-5 with allograft, cage, plate:
Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.
Decision based on Non-MTUS Citation ODG Low Back Chapter.

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

Decision rationale: The California MTUS guidelines do recommend spinal fusion where there is fracture, dislocation or significant instability. The documentation does not show vertebral fracture or significant instability. Her magnetic resonance imaging scan (MRI) shows no severe canal or foraminal stenosis or nerve root impingement. His provider recommended an anterior interbody lumbar arthrodesis to treat her lumbago. Documentation does not present evidence of significant 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. Documentation does not show instability or severe degenerative changes. The requested treatment is not medically necessary and appropriate.

Associated Surgical Service: Hot/cold Therapy Unit: 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.

Associated Surgical Service: Muscle 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.