

Case Number:	CM15-0176606		
Date Assigned:	09/17/2015	Date of Injury:	11/13/2013
Decision Date:	11/09/2015	UR Denial Date:	08/12/2015
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: California, Indiana, Oregon
 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 36 year old female, who sustained an industrial injury on 11-13-13. Medical record indicated the injured worker is undergoing treatment for lumbar disc displacement and status post lumbar discectomy with extremity symptoms. Treatment to date has included L5-S1 discectomy. (MRI) magnetic resonance imaging of lumbar spine performed on 7-21-15 revealed small left paracentral disc protrusion at L2-3 and approximately 6mm broad based central disc protrusion at L5-S1 and interval development of a broad based left foraminal disc protrusion at L3-5 with left foraminal narrowing and mass effect upon the left L3 nerve root. On 6-12-15 she complained of continued low back pain with radiation to left lower extremity and she is on no medication. Currently on 7-28-15, the injured worker complains of continued bilateral low back pain with radiation to her left lower extremity with tingling and numbness to the sole of her foot and toes, she complains of intermittent pain, sharp in character with movement and notes Ibuprofen and Hydrocodone have provided no relief of symptoms. She is not working. Physical exam on 6-12-15 noted well healed incision, pain to palpation of lumbar spine and full strength throughout the bilateral lower extremities. Physical exam on 7-28-15 noted well healed incision on lumbar spine, pain to palpation to the mid-lumbar spine, decreased sensation to left lower extremity, calf, ankle and foot with absent ankle jerks. The treatment plan included transforaminal lumbar interbody fusion at L5-S1. On 8-12-15, utilization review non-certified a request for transforaminal lumbar interbody fusion at L5-S1 noting documentation does not indicate the injured worker has undergone any formalized physical postoperatively for core strengthening or stretching or any other conservative treatments prior to consideration for another surgery and non-certified 3 day inpatient stay,

surgical assistant, Aspen LSO brace and bone growth stimulator noting the requested surgery was non-certified, the requested associated services were also.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal lumbar interbody fusion at L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back.

Decision rationale: The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptoms. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient, there is lack of medical necessity for lumbar fusion, as there is no evidence of segmental instability greater than 4.5 mm, severe stenosis or 3rd disc herniation from the exam notes to warrant fusion. Therefore the request is not medically necessary.

Associated surgical service: Inpatient stay for 3 days post lumbar fusion: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: Assistant surgeon for the lumbar fusion: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: Aspen LSO brace post lumbar fusion: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: Bone growth stimulator post lumbar fusion: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.