MAXIMUS Federal Services

Case Number:	CM15-0064858		
Date Assigned:	04/10/2015	Date of Injury:	07/01/2011
Decision Date:	06/03/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/06/2015

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: 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 59 year old female who sustained an industrial injury on 07/01/2011. The mechanism of injury was not provided. Diagnoses include back pain, lumbar L3 through S1 disc herniation's with marked bilateral foraminal stenosis L3-4, and high-grade critical foraminal stenosis at L4-5, and L5-S1, lumbar radiculopathy, and incontinence of the bowel and bladder. Treatment to date has included surgery, diagnostic studies, medications, cervical injection, and therapy. The progress note dated 03/07/2015 documents the injured worker has constant moderate to severe sharp back pain radiating down into both legs left greater than right with leg spasms, numbness weakness and tingling. She suffered a near complete quadriplegia in 2011, received a cervical anterior posterior fusion and spent 6 months in rehabilitation and made quite a recovery. She was able to walk and had significant improvement in her arm strengths. Since last year she started having decreased strength and her arms and her legs and was dropping things and her legs will give way. She uses a seated walker for ambulation, and ambulates slowly with a wide-based gait. She has Hoffmann's sign bilaterally. The injured worker underwent an MRI of the lumbar spine on 02/18/2015, which revealed, at the level of L3-4, there was no definite evidence for significant subforaminal encroachment, although there was at least moderate left and mild right neural foramina encroachment. There was a mild annular bulge flattening to minimally indenting the ventral thecal sac contributing to at least moderate central spinal stenosis with an AP spinal canal diameter of 7 mm due to superimposed congenitally short pedicles, with mild ligamentum flavum hypertrophy. At L4-5, there was moderate to severe central spinal stenosis, complete effacement of the right and partial effacement of the left

subforaminal recess with significant mass effect on the central L5 nerve roots. There was moderate to severe bilateral right greater than left neuroforaminal encroachment and fatty marrow changes associated with advanced discogenic degenerative changes at L4-5, characterized end plate marrow edema likely symptomatic. At L5-S1, there was minimal discogenic degenerative change, with small superimposed annular bulge, which minimally advanced the ventral thecal sac and fails to produce central spinal stenosis. There was mild left and at least moderate right neuroforaminal stenosis associated. The impression included likely symptomatic marrow edema, L4-5, associated with discogenic degenerative changes. The reflexes were noted to be absent at the ankles, and the strength in the quadriceps was 4/5, as was the strength in the anterior tibialis and extensor hallucis longus muscles. The bilateral iliopsoas strength was 4+/5. The gastroc nemius muscle strength was 4/5. The sensation was diminished completely, bilaterally, to an S1 distribution.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior spinal fusion and decompression L3 through S1 Qty: 1.00: Upheld

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

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

Decision rationale: The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and 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 and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, 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, or spondylolisthesis if there is instability and motion in the segment operated on. Clinicians should consider referral for psychological screening to improve surgical outcomes. The clinical documentation submitted for review failed to provide the injured worker had a failure of conservative care and the duration of conservative care. There was documentation indicating the injured worker had severe stenosis at the level of L4-5. However, there was a lack of documentation indicating the injured worker had significant findings at the level of L3-4 and L5-S1. There was a lack of documentation indicating the injured worker had spinal instability on x-rays to support the need for a fusion. There was a lack of documentation of electrophysiologic evidence of radiculopathy to support decompression. There was a lack of documentation indicating the injured worker had psychological screening, as the fusion would be for multiple levels. Given the above, the request for posterior spinal fusion and decompression L3 through S1 Qty: 1.00, is not medically necessary.

Associated surgical services: 3-day inpatient stay: 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.

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 services: Lumbar brace Qty: 1.00: 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 - post operative (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.

Associated surgical services: Walker Qty: 1.00: 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.

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 services: Cooling unit, rental, lumbar spine Qty: 1.00: 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), Shoulder - Continuous-flow cryotherapy.

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 services: Home health, twice weekly for 2 weeks, lumbar spine Qty: 4.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

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 services: Bone stimulator, purchased lumbar spine Qty: 1.00: 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 - Bone growth stimulators (BGS).

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.