

Case Number:	CM14-0146666		
Date Assigned:	09/12/2014	Date of Injury:	06/01/1990
Decision Date:	10/07/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/08/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 58-year-old female financial clerk sustained an industrial injury on 6/1/90. Injury occurred while assisting another employee who pulled and twisted her left arm. Past medical history was positive for bronchial asthma, depression and anxiety, hypertension, H. pylori gastritis, and gastroesophageal reflux disease. Past surgical history was positive for lumbar fusion from L3 to S1 in 1991 and 1992, hardware removal and L4/5 fusion in 2000, and implantation/explantation of a spinal cord stimulator. The injured worker was diagnosed with failed back surgery syndrome. The 6/3/14 lumbar MRI impression documented post-surgical changes from L3 through S1 with no evidence of any recurrent central canal or foraminal stenosis. There was disc desiccation at L2/3 with moderate to severe disc height loss and degenerative end plate changes with mild bilateral foraminal stenosis. The 7/29/14 thoracic MRI impression documented a mild exaggeration of a thoracic kyphosis centered at T5/6, with no subluxation. There was some mild foraminal stenosis at T9/10 and T10/11 on the left. The 8/6/14 treating physician progress report cited continued mid to low back pain radiating into the lower extremities. Physical exam documented thoracic and L2/3 radicular pain. MRI review noted substantial central canal stenosis at L2/3. A complete neurologic examination was not documented. The 8/20/14 utilization review denied the L2/3 XLIF (eXtreme lateral interbody fusion) and associated requests as there is no guideline support for this procedure or specific objective exam findings relative to the L2/3 nerve distribution. The request for referral for thoracic epidural steroid injection was denied as there was insufficient evidence to support a diagnosis of thoracic radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

L2/3 XLIF (eXtreme lateral interbody fusion) with minimally invasive posterior spinal fusion, intraoperative neuromonitoring: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines); Endoscopic spinal fusion

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, XLIFÂ® (eXtreme Lateral Interbody Fusion)

Decision rationale: The California MTUS does not provide recommendation for extreme lateral interbody fusion (XLIF). The Official Disability Guidelines state that XLIF is not recommended. At best, endoscopic spinal fusion should be limited to conditions outlined for open fusion including spinal fracture, dislocation, or spondylolisthesis. A recent systematic review concluded that there is insufficient evidence of the comparative effectiveness of XLIF versus conventional posterior lumbar interbody fusion or transforaminal lumbar interbody fusion. Guideline criteria have not been met. There is no current clinical exam or imaging findings of nerve root compression or spinal segmental instability to support the medical necessity of lumbar fusion in general. There is no evidence that this patient meets the diagnostic criteria specific to this procedure relative to spinal fracture, dislocation, or spondylolisthesis. Therefore, this request is not medically necessary.

Assistant surgeon: 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.

In-patient two (2) days: 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.

Pre-op medical clearance: H&P, EKG, chest x-ray, labs and PFT test: 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.

LSO 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.

Referral for chronic pain management and for thoracic ESI (epidural steroid injection) under sedation at T5/6: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection (ESIs), Page(s): 46. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) supports the use of epidural steroid injections as an option for the treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Radiculopathy must be documented by physical exam and corroborated by imaging studies and/or electrodiagnostic studies and the patient should have been unresponsive to conservative treatment. Guideline criteria have not been met. There is no current documentation of subjective or clinical exam findings consistent with a diagnosis of radiculopathy at T5/6. Imaging findings do not demonstrate nerve root compression at the T5/6 level. There is no indication that the patient has been non-responsive to other conservative measures. Therefore, this request is not medically necessary.

Medical clearance prior to injection to include H&P, EKG, chest x-ray, labs and PFT test: 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.