

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Spine 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

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

This claimant is a 50-year-old female with a reported date of injury of 07/12/2011. The mechanism of injury was described as injuring her low back lifting a patient, helping with transfers, doing her usual work activities on 07/12/2011. On 10/04/2011, an MRI of the lumbar spine was obtained at L4-5, there was moderate central and lateral recess stenosis and moderately severe right foraminal narrowing secondary to disc bulging and facet hypertrophic changes. There is mild left-sided foraminal narrowing. There is a probable associated foraminal protrusion on the right side at that level. She returned to clinic in 02/2012 at which time she reported 30% improvement from an epidural and she was recommended to lose weight with possible benefit after losing weight from a decompression and TLIF at both L4-5 and L5-S1 because of a spondylolisthesis. In 07/2013, she returned to the clinic and neurological exam was intact with normal strength, normal sensation and normal deep tendon reflexes. She continued to report chronic low back pain at that time. She returned to clinic on 09/30/2013 at which time diagnoses included L4-5 spondylosis, stenosis and spondylolisthesis. Neurologically she was intact. It was noted that she would need an updated MRI, since her old 1 was almost 2 years old and possibly need a discogram from L3-S1 to further evaluate the adjacent levels in her spine. Plan was to proceed with the decompression fusion of L4-5.

IMR DECISION(S) AND RATIONALE(S)

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

1. Decompression and fusion at L4-5 is not medically necessary and appropriate.

The Claims Administrator based its decision on the ODG Low Back Chapter, Spinal Fusion.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Chapter 12, pages 305-307, which are part of the MTUS.

The Physician Reviewer's decision rationale:

This request is for a decompression and fusion at L4-5. California MTUS Guidelines indicate that for surgical indications to the lumbar spine, there should be documentation of severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs and neural compromise. There should be documentation of failure of conservative treatment and there should be "clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in short and long term from surgical repair." Furthermore, "before referral for surgery, clinician should consider a referral for psychological screening to improve surgical outcomes." The diagnoses include spondylosis, stenosis and spondylolisthesis. The MRI of 10/04/2011 indicates that there is severe degenerative changes at both L4-5 and L5-S1 level facets with marked irregularity in the facets at L4-5 with a pars intra-articularis suggesting the subtle spondylolysis. There is 5 mm of anterolisthesis of L4 with respect to L5. Flexion and extension views have not been provided for this review to document objectively that there is instability of the lumbar spine. No psychological evaluation was provided for this review to indicate that the claimant has been cleared from a psychological perspective and there is lack of documentation of significant current conservative care as current physical therapy notes and current interventional injection notes were not provided for this review. In the most recent clinical exam, it was noted that the "neurologic exam of the lower extremities is intact to motor strength, sensation and deep tendon reflexes." Furthermore, it was noted at that time, 09/30/2013, that an updated MRI would be required and consideration would also be given for an L3-S1 discogram to further evaluate the adjacent levels on her spine. The updated MRI was not provided for this review and a discogram was not provided for this review. Furthermore, the most recent clinical note dated 09/30/2013 does not indicate at that time that surgery was to be performed absent those studies. MTUS/ACOEM Chapter 12 further indicates that the surgical treatment for spinal stenosis is usually complete laminectomy. Absent any significant neurological deficits, and absent significant current conservative care, a decompression is not supported by the guidelines. Furthermore, absent documentation of current conservative care and absent a psychological evaluation, and absent flexion and extension views demonstrating instability of the lumbar spine, a fusion is not supported by the guidelines. Therefore, this request is non-certified.

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[REDACTED]

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