

Case Number:	CM13-0022047		
Date Assigned:	03/19/2014	Date of Injury:	06/19/2012
Decision Date:	04/15/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/09/2013

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:

The patient is a 61 year old male who was injured on 06/19/2012 when he tried to break up a fight between two clients and got hit in the right jaw. Prior treatment history has included multiple therapy visits for the shoulder and lumbar spine with no change. Medication history includes Acetaminophen (Tylenol 500mg) and Ibuprofen (Motrin 800mg). The patient underwent a left shoulder arthroscopic extensive glenohumeral joint debridement, left shoulder arthroscopic subacromial decompression, left shoulder arthroscopic distal clavicle excision and a left shoulder arthroscopic rotator cuff repair (complex supraspinatus and infraspinatus tear) on 04/16/2013. Diagnostic studies reviewed include lumbar spine x-rays performed on 08/01/2013, which revealed osteophytes and facet hypertrophy present in the lumbar spine. In the neutral position, the patient demonstrates grade-1 anterolisthesis of L3 on L4. There is also grade 1 retrolisthesis of L2 on L3. With flexion and extension, there is increased anterolisthesis of L3 on L4 with flexion. MRI of the lumbar spine performed on 05/09/2013 revealed bilateral L3 pars interarticularis defects. At the L3 level, osteophytes arising from the L2-L3 facet joints cause moderate to severe central spinal canal narrowing. There is a synovial cyst arising anteriorly off the left L2-L3 facet joint. There is ever bilateral facet degeneration. The synovial cyst, disk bulge, and ligamentum flavum hypertrophy cause mild to moderate central spinal canal narrowing. The lateral recess on the left is severely compressed by the synovial cyst. L3-4 reveals severe bilateral facet degeneration. There is moderate bilateral neural foraminal narrowing. L4-5 reveals moderate to severe bilateral neural foraminal narrowing. L5-S1 reveals moderate bilateral neural foraminal narrowing. A CT of the chest performed on 02/26/2013 revealed no acute cardiopulmonary process. An x-ray of the left shoulder performed on 06/25/2012 revealed no acute fracture is identified. The alignment is normal. No significant joint disease is noted. No significant soft tissue abnormality is identified. The vascular structures

demonstrate no calcifications or other evidence of atherosclerotic disease. A report dated 02/04/2014 documented the patient to have reported his shoulder is not painful, just stiff. His back has not changed since the last visit. The patient indicated that the low back pain is aching and constant. His pain severity is 6/10. He has pain radiation pattern to the bilateral foot posterior. The aggravating factor is any movement. He is off work with no light duty available. Objective findings on exam revealed decreased range of motion (flexion 140, extension 40, and abduction 160). He exhibits no tenderness, no bony tenderness, no swelling, no deformity, no pain and normal strength. The left elbow exhibits normal range of motion. The left wrist exhibits normal range of motion. His cervical back exhibits normal range of motion, no tenderness, no bony tenderness and no pain. His left hand exhibits normal range of motion; normal sensation noted and normal strength noted. The patient was diagnosed with adhesive capsulitis of the left shoulder, lumbar spondylosis; spinal stenosis of lumbar spine and low back pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR SPINE L2-S1 LAMINECTOMY, POSTERIOR FUSION, INSTRUMENTATION, ALLOGRAFT BONE, BMP (BONE MORPHOGENETIC PROTEIN - OFF-LABEL USE), POSSIBLE L5-S1 TLIF, ALLOGRAFT BONE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation ODG, Low Back Chapter; as well as the AMA Guides.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute and Chronic), Bone-morphogenetic protein (BMP), Discectomy/Laminectomy & Fusion (spinal).

Decision rationale: The California MTUS Guidelines state that the surgical treatment for spinal stenosis is usually complete laminectomy. Some evidence suggests that patients with moderate to severe symptoms may benefit more from surgery than from conservative treatment. The Official Disability Guidelines state that symptoms/findings confirm the presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging. Imaging Studies, requiring one of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings: A. Nerve root compression (L3, L4, L5, or S1); B. Lateral disc rupture; or C. Lateral recess stenosis. The California MTUS Guidelines also state that there is no good evidence from controlled trials that spinal fusion alone is effective for treatment of any type of acute low back problems, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on.

POST-OPERATIVE PHYSICAL THERAPY (20 SESSIONS): 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.