

Case Number:	CM13-0024920		
Date Assigned:	11/20/2013	Date of Injury:	08/07/2007
Decision Date:	01/16/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	09/16/2013

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 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. 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 56-year-old female who reported a work-related injury on 08/07/2007, as a result of strain to the lumbar spine. Subsequently, the patient presents for treatment of the following diagnoses, myofasciitis/muscle spasms, stress/anxiety, hypertension with medications, sexual dysfunction, insomnia, cervical spine disc syndrome, and thoracic spine disc syndrome, lumbar spine disc syndrome, pain in the thoracic spine, pain in the lumbar spine, pain in the cervical spine, bilateral shoulder pain, bilateral elbow pain, and bilateral wrist pain. MRI of the patient's lumbar spine dated 02/19/2013 signed by [REDACTED] revealed: (1) An L2-3 broad-based disc protrusion that abuts the thecal sac combined with facet ligamentum flavum hypertrophy, there was spinal canal narrowing as well as bilateral neural foraminal narrowing. (2) At the L3-4, there was a 1 mm to 2 mm grade I retrolisthesis of L3 on L4 and there was a broad-based disc protrusion that abuts the thecal sac combined with facet ligamentum flavum hypertrophy. There was spinal canal narrowing as well as bilateral neural foraminal narrowing. (3) At the L4-5 level, a 10.9 mm grade II spondylolisthesis of L4 and measures 11 mm in flexion and 10.9 mm in extension. Combined with a disc protrusion and facet ligamentum flavum hypertrophy, there was spinal canal narrowing and bilateral lateral recess and neural foraminal narrowing. (4) at the L5-S1 level, there was a 3.1 mm grade I spondylolisthesis of L4. This measured 3.1 mm in flexion and 3.1 mm in extension combined with a mild disc protrusion and facet and ligamentum flavum hypertrophy. There was spinal canal narrowing and bilateral neural foraminal narrowing. (5) Hemangioma at L2. (6) No other significant findings noted. Lumbar spinal discogram dated 04/08/2013 performed by [REDACTED] revealed positive discography at L3-4, L4-5 and L5-S1. The clinical note dated 06/03/2013 reports the patient was seen for an orthopedic spine evaluation. The provider D

IMR ISSUES, DECISIONS AND RATIONALES

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

An inpatient lumbar anterior and posterior discectomy and fusion with instrumentation:
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): 306-307.

Decision rationale: The current request is not supported. The clinical documentation submitted for review showed evidence that the patient presents with continued significant functional deficits about the lumbar spine status post a work-related injury sustained in 2007. The requesting provider documents the patient has exhausted all lower levels of conservative treatment for her pain complaints. The provider is recommending the patient undergo an L3-4, L4-5 and L5-S1 anterior and posterior lumbar fusion and discectomy. The patient presented with 5/5 motor strength noted throughout. The provider documented the patient's sensation was intact throughout with the exception of the bilateral midfoot at the L5 dermatome. Review of the patient's imaging of the lumbar spine fails to evidence support for the requested operative procedure, the patient does not require stabilization of the spine at the L4-5 level, discectomy and fusing at all 3 levels is not indicated. There was no nerve root involvement evidenced at the L3-4 or L4-5 levels to support decompression. The California MTUS/ACOEM indicates, "Direct methods of nerve root decompression include laminotomy, standard discectomy and laminectomy." Given all of the above, the request for inpatient lumbar anterior and posterior discectomy and fusion with instrumentation is not medically necessary or appropriate.

Inpatient length of stay for three (3) days: Upheld

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

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 Chapter

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Outpatient post operative physical therapy two (2) times per week for six (6) weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s):
26.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Outpatient post operative appointment: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.