

Case Number:	CM13-0039454		
Date Assigned:	12/18/2013	Date of Injury:	08/15/2011
Decision Date:	05/14/2014	UR Denial Date:	09/04/2013
Priority:	Standard	Application Received:	10/04/2013

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 Texas. 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 57-year-old male who reported an injury on 08/15/2011. The mechanism of injury was not provided. The patient underwent an MRI of the lumbar spine without contrast on 07/23/2013, which revealed at L2-3 the patient had a subtle progression since the most recent MRI of 01/30/2012, in osteophytic ridging and accompanying left-sided disc material narrowing the left lateral recess and probably deflecting left-sided nerve roots within the thecal sac. The left foramen was slightly narrowed along its underside. There were stable discogenic degenerative changes at L1-2. There were no fractures, pars defect, or osseous lesion. Discogenic reactive changes were most prominent at the L2-3 level. In regards to the alignment, there was a stable appearance of a mid and lower lumbar dextroscoliotic curvature. Per recent documentation, the physician opined that there was no instability in the classic sense. The patient was noted to have no radicular weakness, numbness, or reflex changes. The patient had a negative straight leg raise and negative hip range of motion. There were extensive edema changes in the vertebral bodies adjacent to the L2-3, more than L1-2. The physician further opined a fusion had about a 50% chance of producing an improvement of 75% or more, and that the operation would not make the patient pain free. The patient did not respond to physical therapy, injection therapy, or rest and time. The impression was noted to be low back pain. The request was made for a T12-L3 fusion and a 2-day inpatient stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

T12-L3 fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 209-211.

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

Decision rationale: ACOEM Guidelines indicate a surgical consultation is appropriate for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain or extreme progression of lower leg symptoms, 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 a failure of conservative treatment to resolve disabling radicular symptoms. For a spinal fusion it further indicates that for patients with increased spinal instability not work-related after surgical decompression at the level of degenerative spondylolisthesis, a fusion may be appropriate. The clinical documentation submitted for review indicated the patient had an MRI which revealed no spondylolisthesis and no instability. There was, however, at L2-3 osteophytic ridging and accompanying left-sided disc material, narrowing of the left lateral recess, and deflecting of the left-sided nerve root within the thecal sac. The alignment was noted to be stable. The patient was noted to have no radicular weakness, numbness, or reflex changes. The patient had a negative straight leg raise and negative hip range of motion. The physical examination, per the physician, revealed no instability. There was no notation of a previous surgical decompression. Given the above, the request for T12-L3 fusion is not medically necessary.

2 day inpatient stay: 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.