

Case Number:	CM13-0049445		
Date Assigned:	12/27/2013	Date of Injury:	06/04/2009
Decision Date:	06/09/2014	UR Denial Date:	10/30/2013
Priority:	Standard	Application Received:	11/07/2013

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 Neurological Society, 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 record indicates that the claimant is a 52-year-old individual with a date of injury of June 4, 2009. A neurosurgical progress report dated October 16, 2013 indicates that the claimant has persistent low back pain. A CT myelogram from September 2013 is provided for review, which indicates evidence of severe degenerative disc disease with a slight retrolisthesis and severe stenosis with severe right-greater-than-left degenerative disc disease. Moderate stenosis is noted at L3-4 and slight retrolisthesis is reported at L5-S1. This progress note provides no physical examination and minimal subjective complaints. A subsequent progress note dated August 7, 2013 also notes a complaint of low back pain and a statement that the claimant does not want to proceed with surgery. A neurosurgical report from August 2012 indicates a subjective complaint of low back pain with occasional radiation to the left lower extremity to the small two toes with paresthasias of the left foot. A notation is made that the claimant appears to be obese and chemically altered at times. The back is not tender to palpation with a decreased range of motion. Motor of the bilateral lower extremities is normal, at 5/5. Sensory testing reveals deficits at the left lateral leg and foot. Deep tendon reflexes are 2+ at the ankle and knees bilaterally. Straight leg raise is negative on the right and positive on the left. An MRI from August 2012 demonstrates discogenic end plate changes at L4-5 with multilevel disc space narrowing at L3-S1. At L3-4, there is a minimal posterior disc bulge without central or foraminal stenosis. At L4-5, there is a mild posterior disc bulge with narrowing of the thecal sac to 7-8mm in the midline anteroposterior diameter. Shortened pedicles are noted. There is mild bilateral foraminal stenosis. At L5-S1, a mild posterior disc bulge is superimposed upon a right foraminal lateral protrusion of 5mm. Moderate foraminal stenosis is present on the right, and mild foraminal stenosis is present on the left. Pool therapy and a home exercise regimen are recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT L4-5 POSTERIOR OBLIQUE LUMBAR ARTHRODESIS WITH POSTEROLATERAL FUSION INSTRUMENTATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The ACOEM guidelines support lumbar fusion procedures in a clinical setting where an unstable vertebral fracture exists, or where surgery is being performed for tumor, infection, or other disease processes that led to spinal motion segment instability (i.e. translation greater than or equal to 5mm of the superior vertebral body on the inferior vertebral body from the full extension film to the full flexion films). Other criteria include a total angular movement during flexion and extension at the unstable level that is at least 20° greater than the motion present at the adjacent disc. The record provides no clinical evidence of lumbar radiculopathy that correlates with the imaging studies provided. Additionally, the record does not provide evidence of a spondylolisthesis that meets the guideline criteria for consideration of fusion, following the appropriate documentation of conservative treatment, and in the presence of appropriate documentation of the clinical presentation. Therefore, this request is recommended for non-certification.

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.

BONE STIMULATOR: 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.

TLSO 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.