

Case Number:	CM13-0051562		
Date Assigned:	12/27/2013	Date of Injury:	01/06/2004
Decision Date:	04/24/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	11/14/2013

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 Spine Surgery, and is licensed to practice in New York. 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 middle-aged female who complains of chronic back pain radiating to the lower extremities. Her date of injury was January 9, 2006. On physical examination she has tenderness to palpation of the lumbar paraspinal musculature. Spasm and guarding is present. She has reduced range of motion of the lumbar spine. Straight leg raise is positive on the left and negative on the right. There is decreased sensation of the left side at L4-L5 and S1. X-rays from March 2013 showed slight spondylolisthesis at L4-5. MRI from July 2013 shows disc protrusion at L4-5 and L5-S1. There is slight spondylolisthesis. There is disc protrusion at L4-5 impinging on the thecal sac and narrowing the central and lateral recesses. There is disc protrusion at L5-S1 causing central lateral recess stenosis. Patient has had conservative treatment including rest therapy, medication and pain management without success. At issue is whether surgical two-level decompression and fusion is medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

A BILATERAL L4-5 AND L5-S1 DECOMPRESSION: Upheld

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

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

Decision rationale: This patient has not been established criteria for lumbar decompressive surgery. There is no evidence that a recent trial of physical therapy was conducted. In addition, there is no evidence that the patient had epidural steroid injection therapy. Conservative measures have not been maximized. More conservative measures must be tried and failed. Also, the patient does not have severe progressive neurologic deficit documented in the medical records. More conservative measures must be tried at this time to include physical therapy and epidural steroid injection. Therefore, surgery for lumbar decompression is not medically necessary at this time.

A L4-S1 ANTERIOR LUMBAR INTERBODY FUSION WITH CAGE AND

ALLOGRAFT: Upheld

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

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

Decision rationale: This patient does not meet established criteria for lumbar fusion surgery. Specifically, the medical records do not document any evidence of lumbar instability. There is no documentation of flexion-extension views showing abnormal motion or any level of the lumbar spine. In addition, the patient has no red flag indicators for spinal fusion surgery such as fracture, tumor, or progressive neurologic deficit. Since there is no spinal instability present, two-level lumbar fusion surgery is not medically appropriate in this patient. Criteria for fusion surgery are not met.

A L4-S1 POSTEROLATERAL FUSION WITH SCREWS AND ALLOGRAFT: Upheld

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

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

Decision rationale: This patient does not meet established criteria for lumbar fusion surgery. Specifically, the medical records do not document any evidence of lumbar instability. There is no documentation of flexion-extension views showing abnormal motion or any level of the lumbar spine. In addition, the patient has no red flag indicators for spinal fusion surgery such as fracture, tumor, or progressive neurologic deficit. Since there is no spinal instability present, two-level lumbar fusion surgery is not medically appropriate in this patient. Criteria for fusion surgery are not met.

VASCULAR SURGEON ASSISTANCE FOR ANTERIOR INTERBODY FUSION:

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.

A TWO DAY INPATIENT HOSPITAL 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.