

Case Number:	CM13-0053506		
Date Assigned:	12/30/2013	Date of Injury:	07/17/2012
Decision Date:	03/10/2014	UR Denial Date:	11/06/2013
Priority:	Standard	Application Received:	11/18/2013

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, has a subspecialty 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 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 37-year-old male with his date of injury July 17, 2012. The patient was injured while digging a trench with a shovel. He complains of chronic low back pain. He also has left radicular pain to the foot. Physical exam findings include tenderness to palpation of the lower lumbar spine and painful range of lumbar motion. He has a positive left-sided sitting straight leg raise. He has a positive right-sided crossover straight leg raise. Sensation is diminished along the left calf left thigh. There is no atrophy and normal muscle strength with the exception of the bilateral tibial anterior muscles which are 4 minus over 5 EHL is bilateral to 4 minus over 5. Patella and ankle reflexes are 1+ bilaterally. The patient has had acupuncture and electrical stimulation without relief. Patient has also had pharmacologic management and lumbar epidural steroid injections and physical therapy. Lumbar x-ray from September 2013 was within normal limits and no abnormal motion normal flexion-extension views. Nerve conduction study performed in May 2013 was normal with no evidence of radiculopathy. An abnormal EMG revealed chronic left S1 denervation with no other active lumbar radiculopathy. MRI from April 2013 shows L4-5 decreased disc height with a 3 mm broad disc protrusion with mild to moderate central stenosis but nor foramina are maintained. At L5-S1 this a 4 mm disc protrusion slightly abutting and displacing the S1 nerve is more on the left, none on the right. At issue is whether multilevel decompressive and fusion surgery is medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

one (1) lumbar laminectomy with instrumentation and fusion at L4-L5 and L5-S1 levels:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288, 305, 306, 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305 and 307. Decision based on Non-MTUS Citation Spinal Fusion and the Surgery for low back pain: a review of the evidence for an American Pain Society Clinical Practice Guideline

Decision rationale: This patient does not need to establish criteria for lumbar decompression and fusion surgery. Specifically, the patient's lumbar MRI and imaging studies do not demonstrate any evidence of instability. There is also no red leg indicators for spinal surgery such as tumor, fracture, or progressive neurologic deficit. Criteria for fusion are not met. Criteria for decompression are not met because the patient's physical exam findings does not clearly correlate with MRI evidence of significant nerve root compression. There is very mild compression of the bilateral S1 nerve roots on the MRI. The patient's physical exam does not clearly document specific and isolated radiculopathy that would require decompression. In addition the imaging studies do not correlate with the physical examination respect to specific isolated nerve root findings for decompression. The patient does not have progressive neurologic deficit. The patient does not have significant radiculopathy related to compression on imaging studies. Criteria for lumbar decompression are clearly not met.