

Case Number:	CM13-0056039		
Date Assigned:	12/30/2013	Date of Injury:	06/14/2012
Decision Date:	03/26/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	11/21/2013

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 Spine 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 31-year-old male who reported injury on 06/14/2012. The mechanism of injury was noted to be the patient was attempting to push a cabinet with a dolly under a doorway which was shorter than the height of the cabinet. The cabinet got stuck in the doorway and the patient injured his low back. The patient was noted to undergo a left L4-S1 transforaminal epidural steroid injection in 2012. The patient underwent treatment with acupuncture and physical therapy. Per the submitted physician notes, the patient underwent an MRI of the lumbar spine without contrast on 10/05/2012 which revealed mild disc desiccation associated with 4 mm focal central protrusion and at the level of L5-S1, there was moderate disc desiccation associated with a 3 mm bulge and there was superimposed left foraminal disc protrusion and out annular tear seen on sagittal images. There was mild bilateral right and severe left-sided foraminal narrowing due to a forward slip, disc bulging and scoliosis. There was marked compression of the exiting L5 nerve root. The patient had a nerve conduction study on 10/01/2013 which revealed a normal study of the bilateral lower extremities. The documentation to request the posterior spinal fusion and decompression was not provided for review. Per the Agreed Medical Examination, the patient had discomfort and pain radiating to the left leg. The submitted request was for a posterior spinal fusion and decompression at L4-S1. Sensation was noted to be intact to all dermatomes and motor strength was intact to all myotomes. Additionally, per the AME, there was evidence of spina bifida occulta with spondylolysis. The patient's diagnoses were noted to include lumbar sprain or strain, lumbar intervertebral disc displacement without myelopathy and neuritis/radiculitis of the lumbosacral area.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior Spinal Fusion and Decompression L4-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Discectomy/Laminectomy

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

Decision rationale: The ACOEM Guidelines indicate that surgical consultations are appropriate for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy preferably) with accompanying signs of neural compromise, activity limitations due to radiating leg pain, clear clinical, imaging and electrophysiological evidence or 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. Additionally, it indicates that patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be a candidate for fusion. There was lack of documentation indicating the official MRI results. Per the Agreed Medical Evaluation, the patient had no myotomal or dermatomal findings to support the requested surgery. The clinical documentation submitted for review failed to support the requested surgery. The nerve conduction study revealed a normal study of the bilateral extremities. There was a lack of documentation of the specific note requesting the procedure. Given the above and the lack of documentation to support a necessity for surgery for the levels of the surgical request, the request for posterior spinal fusion and decompression L4-S1 is not medically necessary.