

Case Number:	CM13-0057086		
Date Assigned:	12/30/2013	Date of Injury:	12/29/2012
Decision Date:	04/15/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	11/25/2013

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 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 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 claimant is a 28-year-old gentleman who injured his low back while pulling a filing cabinet on December 29, 2012. The medical records provided for review included an October 13, 2013 follow-up report by [REDACTED] who noted that the claimant continued with pain in the low back. The documentation indicated that the claimant received no improvement with conservative care including physical therapy, medication management, and activity restrictions. Physical examination findings showed tenderness of the lumbar spine with restricted range of motion, 4/5 strength bilaterally with knee extension and knee flexion. There was diminished sensory examination in an L4 through S1 dermatomal distribution bilaterally. Formal imaging reports were not available for review. However, the treating physician documented that a previous MRI from April 2013 showed central stenosis at the L4-5 and L5-S1 level with neural foraminal narrowing and impingement upon the exiting right L5 nerve root. Previous electrodiagnostic studies from April of 2013 also demonstrated radiculopathy at the L4-5 level. Documentation indicated that review of plain film radiographs revealed diminished disc height at the L5-S1 level, but no evidence of segmental instability. Lumbar fusion was recommended with bone grafting at two levels, L4-5 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

one Surgery of the Transforaminal Lumbar Interbody Fusion, Instrumentation and Bone Grafting of L4-5 and L5-S1 between 11/13/2013 and 12/28/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Version, Low Back Chapter, Patient Criteria for Lumbar Spinal Fusion

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

Decision rationale: Based on California ACOEM Guidelines, lumbar fusion at the two requested levels would not be indicated. The claimant's clinical picture gives continued documentation of radicular findings but there is no documentation of evidence of segmental instability to warrant or indicate the need for a fusion procedure. ACOEM Guidelines do not recommend surgical fusion in absence of lumbar fracture, dislocation or segmental instability. The absence of the above documentation would fail to support the ACOEM Guidelines for the current surgical request.