

Case Number:	CM13-0062479		
Date Assigned:	12/30/2013	Date of Injury:	04/14/2011
Decision Date:	04/07/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/06/2013

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 Spine Surgery, and is licensed to practice in Texas. 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 45-year-old male who reported injury on 01/14/2011. The mechanism of injury was noted to be the patient fell through some boards and injured his right knee, left elbow, and low back. Per an office note dated 03/22/2012, the patient had an MRI of the lumbar spine on 08/16/2011, which revealed, at L4-5, there was a disc protrusion that abutted the thecal sac, facet ligamentum flavum hypertrophy was noted, and there was mild spinal canal narrowing and bilateral neural foraminal narrowing. The patient's diagnoses were noted to include low back pain and lumbago. The physical examination revealed that the patient had worsening of his symptoms and the pain was a 9/10 despite anti-inflammatories and physical therapy, as well as injections. The patient had tenderness to palpation over the paraspinal musculature. Flexion was limited to 50 degrees and extension was 25/25 degrees, and right bend was 25/25 degrees as was left bend. It was indicated that the patient had a lumbar MRI on 11/14/2013, which showed L4-5 disc herniation that was broad, causing foraminal stenosis bilaterally, as well as disc desiccation. The assessment was noted to be L4-5 stenosis. The plan indicated the patient was a candidate for L4-5 decompression and fusion since the patient had failed conservative treatment for more than 6 months and had a neurologic deficit that was concordant with MRI findings. The patient had a positive straight leg raise sign bilaterally and had decreased sensation over bilateral L5 dermatomes. It was further opined that surgery may be indicated if compression caused removal of more than 50% of facets, which would cause iatrogenic instability. The request was made for an L4-5 decompression and possible fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient L4-5 decompression and fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 305-306.

Decision rationale: ACOEM Guidelines recommend a surgical consultation for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging, preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than 1 month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. There should be documentation of clear nerve root involvement. Regarding fusions, patients with increased spinal instability (not work related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. The clinical documentation submitted for review indicated that the patient had failed physical therapy and anti-inflammatories, as well as injections. The patient had decreased sensation of the bilateral L5 dermatomes. The physician opined that patient was a candidate for a decompression and due to the decompression, the patient would have iatrogenic spinal instability, if there was a need to remove more than 50% of the facets. The documentation indicated the patient had a lumbar MRI on 11/14/2013, however, the official read was not provided for review. Given the above, the request for Inpatient L4-5 decompression and fusion is not medically necessary.