

Case Number:	CM13-0063226		
Date Assigned:	12/30/2013	Date of Injury:	08/04/2011
Decision Date:	04/03/2014	UR Denial Date:	11/04/2013
Priority:	Standard	Application Received:	12/09/2013

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 Texas and 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 70-year-old female who reported an injury on August 04, 2011 after a fall from a ladder. The patient reportedly injured her low back and right hip. The patient underwent an EMG/NCV in January 2012 that documented there was evidence of bilateral L4-5 radiculopathy. The patient underwent an x-ray examination of the lumbar spine in July 2012 that documented the patient had an 8 mm L4 on L5 with severe degenerative disc disease. The patient underwent a psychological evaluation in July 2013 that documented that the patient was psychologically cleared to undergo fusion surgery. The patient's most recent clinical examination document that the patient has continued urinary incontinence and urgency and extreme pain in the lumbar spine with weakness of the lower extremity and cane dependency. There were no recent physical examination findings submitted for review. The patient's diagnoses included neurogenic bladder, instability of the lumbar spine, radiculopathy of the lumbar spine, spondylolisthesis grade 1 of the L4, painful gait and dependency, compression fracture of the lumbar spine at the L5, and closed pubic ramus fracture. The patient's treatment plan included surgical fusion of the L4-5 level.

IMR ISSUES, DECISIONS AND RATIONALES

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

decompression laminectomy and interbody fusion at the L4-5 level with posterior instrumentation with a one (1) day inpatient stay.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (spinal)

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has a grade 1 spondylolisthesis at the L4 on the L5. However, Official Disability Guidelines state that surgical intervention in the way of fusion surgery is not generally recommended for a grade 1 or grade 2 spondylolisthesis. The clinical documentation does indicate that the patient does have significant mechanical pain complaints. However, the patient's most recent documentation does not provide any evidence of neurological deficits that have been objectively evaluated to support surgical intervention. The American College of Occupational and Environmental Medicine recommend fusion surgery for patients who have documentation of spinal instability that significantly interferes with the patient's activities of daily living and are supported by documentation of physical findings and corroborated by an imaging study. The clinical documentation does indicate that the patient recently underwent an MRI that indicates the patient has severe spinal canal stenosis. However, that MRI was not provided for review. Additionally, as there are no recent, clinical examination findings that provide significant neurological deficits that would benefit from surgical repair; surgical intervention is not supported at this time. As such, the requested decompression, laminectomy, and interbody fusion at the L4-5 with posterior instrumentation and 1-day inpatient stay is not medically necessary or appropriate.