

Case Number:	CM13-0065849		
Date Assigned:	02/03/2014	Date of Injury:	12/04/2012
Decision Date:	06/12/2014	UR Denial Date:	11/14/2013
Priority:	Standard	Application Received:	12/11/2013

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 patient is a 48 year old male who was injured on 12/4/12 while he was driving a truck that had a broken seat. The truck bounced a lot while he was driving it, and after three continuous days of driving, he could not get out of bed due to severe low back pain. Prior treatment history has included acupuncture, and 13 sessions of physical therapy. The patient underwent six extracorporeal shockwave therapies on 4/11/13. The patient underwent a left lumbar facet injection under fluoroscopy at L3-L4, L4-L5, and L5-S1 (medical branch block) on 6/14/13; radiofrequency right lumbar facet neurotomy at L3-L4, L4-L5, and L5-S1 under fluoroscopy on 4/16/13; and right lumbar L4-L5 and L5-S1 transforaminal epidural injection on 2/27/13. EMG/NCS on 4/11/13 revealed no electrodiagnostic evidence of lumbar radiculopathy bilaterally. X-rays of the lumbosacral spine dated 1/29/13 demonstrated disc space narrowing at L5-S1 with facet hypertrophy bilaterally and no fracture, spondylolysis, or listhesis. An MRI of the lumbar spine without contrast from 1/4/13 demonstrated no stress injury or compression deformity. There is a 2-3 mm broad-based central protrusion at L4-L5 effacing the anterior thecal sac. There is a bilateral facet arthropathy. There is no significant spinal canal or neural foraminal stenosis. There is no significant change compared to prior examination. There is a 2-3 mm broad-based central disc/osteophyte complex at L5-S1 effacing the anterior thecal sac. There is no change compared to prior examination. There is bilateral facet arthropathy. There is a mild neural foraminal narrowing. The spinal canal remains patent. There is no change compared to prior examination. A PR2 dated 1/14/14 indicates that the patient states that the lumbar spine pain is the same, right side greater than left. He has constant sharp pain that radiates down the right lower extremity and right big toe. The patient states he has constant numbing aching pain. The pain causes difficulty sleeping, as well as when he first wakes up in the morning with stiffness in the right buttocks. Acupuncture has constantly helped reduce pain and muscle spasms

in the lumbar spine. Objective findings on exam revealed decreased range of motion as well as pain at the lumbar spine with positive straight leg raise on the right at 45 degrees; positive Lasegue's differential and Eli's in the right lower extremity; and the big toe extensors (L5) at a 4. There is decreased motor strength secondary to pain in his lower extremities. The patient is diagnosed with lumbar disc herniation, lumbar radiculopathy, muscle spasms, lumbar sprain/strain, and thoracic sprain/strain. A PR2 dated 9/30/13 reports that the patient presents with complaints of ongoing pain in his back as well as pain down his right lower extremity. On physical examination, the lumbar spine revealed focal tenderness at L4-L5, L5-S1, more so on the right than on the left. The range of motion exhibits forward flexion to 45 degrees and extension to 30 degrees. Motor examination is normal at 5/5 bilaterally. Deep tendon reflexes are 1+ bilaterally. His sensory exam assessed by the pinwheel, and sensation is within normal limits in the bilaterally lower extremity. Straight leg raise is 8 degrees bilaterally. The patient is diagnosed with discopathy L5-S1 (possibly also L4-L5) and facet arthrosis L4-L5.

IMR ISSUES, DECISIONS AND RATIONALES

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

INPATIENT STAY 3 - 5 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

ASSISSTANT SURGEON: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

CO-SURGEON: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

VASCULAR SURGEON: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

PRE-OP CLEARANCE CONSULTATION; LABS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

CHEST X RAY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

ANTERIOR LUMBAR INTERBODY WITH PLACEMENT OF ARTIFICIAL DISK AT L4-L5 , FUSION L5 - S1: Upheld

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

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

Decision rationale: According to the California MTUS guidelines, spinal fusion may be recommended for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. According to the Official Disability Guidelines, disc prosthesis is not recommended. While artificial disc replacement (ADR) as a strategy for treating degenerative disc disease has gained substantial attention, it is not possible to draw any positive conclusions concerning its effect on improving patient outcomes. Though L-ADR for degenerative disc disease has been compared with lumbar fusion, not all patients who get a fusion are candidates for L-ADR, including patients with nerve root compression, spondylolisthesis, stenosis, facet mediated pain and osteoporosis. In fact, the proportion of patients who have an indication for L-ADR make up only about 5% of those who might undergo lumbar fusion. The medical records document the patient had complained of low back pain radiating to the right lower extremity. On physical examination there was focal tenderness at paralumbar spinal muscles more in the right side, restriction of range of motion, and intact motor and sensory examinations. In the absence of documented spondylosis and spondylolisthesis at L4-L5, and L5-S1, further, lack of documentation radiculopathy in the lower extremities, the request is not medically necessary.