

Case Number:	CM13-0069551		
Date Assigned:	03/03/2014	Date of Injury:	08/01/2011
Decision Date:	09/18/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/23/2013

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:

This is a 70-year-old male with a August 1, 2011 date of injury. He hurt his back while using a pallet jack. From a December 3, 2013 report, the patient describes subjective complaints of continuous low back pain, right leg pain, and intermittent left leg pain with tingling. These symptoms have continued despite having back surgery on April 19, 2013 in which a hemilaminectomy and microdiscectomy were performed. Objective findings include normal lower extremity strength and sensation, normal reflexes, and negative provocative maneuvers. EMG/NCS of the lower extremities demonstrated a chronic or remote right L5 radiculopathy but also polyphasic potentials at S1. A CT myelogram done on July 26, 2013 noted degenerative changes at L5-S1, projecting osteophytes, but no mention of nerve root compromise. An MRI on June 17, 2013 showed no disc extrusion but only protrusions at T11-12 and L3-4. A lumbar xray with flexion/extension views on December 19, 2013 showed degenerative changes at L5-S1, grade 1 anterior spondylolisthesis of L4-5. Diagnostic impression: lumbar spondylosis. Treatment to date: medication management, exercises, selective nerve root block, lumbar hemilaminectomy and microdiscectomy on April 19, 2013. A UR decision dated December 3, 2013 denied the surgical request for L5-S1 decompression and fusion on the basis that there was no clear radiculopathy documented, no radiographic evidence of nerve root compression, and no evidence of spinal instability requiring fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

L-5 - S1 DECOMPRESSION WITH 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): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

Decision rationale: The Low Back Complaints Chapter of the ACOEM Practice Guidelines states that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one 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. In addition, CA MTUS states that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. In the present case, there is no new documentation that would support the proposed lumbar decompression and fusion at L5-S1. There is a new x-ray report from December 19, 2013 which shows L4-L5 grade I anterolisthesis, but there is no evidence of instability at L5-S1 for which a fusion might be indicated. There is poor evidence that a delayed instability can result from the patient's prior procedure, which was a single level hemilaminectomy and discectomy. In addition, the patient did not even have partial relief from the prior lumbar decompressive surgery, which is concerning. The MRI and myelogram since the prior surgery do not support that there is a recurrent disc extrusion and there is no increase in foraminal stenosis. Therefore, the request for L5-S1 decompression with fusion is not medically necessary or appropriate.