

Case Number:	CM14-0127619		
Date Assigned:	09/23/2014	Date of Injury:	07/12/2011
Decision Date:	12/12/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/12/2014

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 51 year-old female with a 7/12/11 date of injury which occurred while lifting and transferring a 180-pound female multiple times during the course of a day. The patient was most recently seen on 6/25/14 with complaints of lower back pain radiating to the right leg. Exam findings revealed lumbar spine range of motion to be essentially within normal limits, with a negative straight leg raise, bilaterally. Neurological examination demonstrated no sensory or motor deficits, and the reflexes were intact. An MRI of the lumbar spine dated 1/14/14 (actual report not included) showed severe facet degeneration, with irregularity of the pars interarticularis bilaterally, and a stable (from prior exam) 6 mm anterolisthesis. There is now a moderate to severe right foraminal stenosis, which had progressed since the previous exam. There is also a mild left foraminal stenosis. The patient's diagnoses included: 1) L4-5 spondylosis, stenosis, and spondylolisthesis. 2) Right sciatica. 3) Degeneration of lumbar intervertebral disc. An EMG/NCV dated 7/21/14 showed evidence of a chronic L4 lumbar radiculopathy with some sparse evidence of ongoing denervation on the left. There was also evidence of a mild generalized sensory-motor polyneuropathy. The medications included Cyclobenzaprine. Significant Diagnostic Tests: MRI lumbar spine; electromyogram/nerve conduction velocity (EMG/NCV), lower extremities. Treatment to date: medication, physical therapy, epidural steroid injection. An adverse determination was received on 7/30/14 due to complaints of radicular back pain, but no neurological findings on physical exam, and no evidence of instability. Furthermore, a pre-surgical psychosocial screening evaluation had not been performed, and there was no documentation of the patient having been tried and having failed on non-surgical, conservative care.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 Transforaminal interbody 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): 305-307.

Decision rationale: CA MTUS 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. This patient has received medical care for an industrial low back injury that occurred 3 years ago. According to the records provided, she has had physical therapy, and one ESI of the lumbar spine, which resulted in a dural puncture headache. It is unclear whether the ESI was clinically beneficial. The patient apparently has multiple allergies and sensitivities to medications, especially opiates, which has undoubtedly limited the pharmacotherapeutic options available for pain management. On the most recent clinical encounter, the patient complained of continued lower back pain, with radiation to the right leg. Physical exam, however, demonstrated unimpaired ranges of motion in the lumbar spine, and normal neurological findings. A recent MRI revealed a moderate to severe right foraminal stenosis, which had progressed since the previous exam, and an EMG/NCV showed evidence of a chronic L4 lumbar radiculopathy. While the diagnostic studies do support intervertebral disc pathology at the L4-5 level, there are no neurological deficits present on clinical exam, and no evidence of instability that would meet the criteria for surgical intervention. Therefore, the request for L4-5 transforaminal interbody Decompression and Fusion is not medically unnecessary.