

Case Number:	CM14-0133414		
Date Assigned:	08/25/2014	Date of Injury:	04/23/2012
Decision Date:	09/25/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/20/2014

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 Physical Medicine and Rehabilitation 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:

According to the records made available for review, this is a 61-year-old male with a 4/23/12 date of injury. At the time (7/16/14) of request for authorization for Anterior Retroperitoneal Exposure, Decompression and Stabilization at L5-S1, 3 Night Inpatient Stay, Assistant Surgeon, and LSO Back Brace, there is documentation of subjective (constant severe pain in low back radiating to knees with numbness and tingling in left foot, bilateral leg weakness, and loss of bladder control) and objective (tenderness over the lumbar spine with spasms, positive bilateral straight leg raising test, decreased lumbar range of motion with pain, decreased sensation over the bilateral L5 and S1 dermatomes, and 2/4 bilateral patellar reflex) findings, imaging findings (MRI of the lumbar spine (1/25/13) report revealed L5-S1 disc compression and dessication; 3 mm retrolisthesis of L5 over S1; bulky hypertrophic facet arthrosis, adequate central dimensions; and bilateral osteophytic narrowing of the neural foramina with suspicious compression of exiting L5 nerve roots), current diagnoses (L5-S1 spondylolytic spondylolisthesis with spinal instability, severe foraminal stenosis, and lower extremity radiculopathy), and treatment to date (medications, epidural steroid injections, physical therapy, and acupuncture).

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Retroperitoneal Exposure, Decompression and Stabilization at L5-S1: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 209-211, Chronic Pain Treatment Guidelines Lumbar Spinal Fusion

Surgery. Decision based on Non-MTUS Citation Official Disability Guidelines, Lumbar Spinal Fusion Surgery.

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, Discectomy/laminectomy.

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; and activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, as criteria necessary to support the medical necessity of laminotomy/fusion. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities), as criteria necessary to support the medical necessity of decompression. Within the medical information available for review, there is documentation of diagnoses of L5-S1 spondylolytic spondylolisthesis with spinal instability, severe foraminal stenosis, and lower extremity radiculopathy. In addition, there is documentation of subjective (pain, numbness, and tingling) and objective sensory changes) radicular findings in the requested nerve root distribution, and imaging (MRI) findings (nerve root compression) the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities). Therefore, based on guidelines and a review of the evidence, the request for Anterior Retroperitoneal Exposure, Decompression and Stabilization at L5-S1 is medically necessary.

3 Night Inpatient Stay: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines, Lumbar Spinal Fusion Surgery.

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, Discectomy/laminectomy.

Decision rationale: There is documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for 3 Night Inpatient Stay is medically necessary.

Assistant Surgeon: Overturned

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, Discectomy/laminectomy.

Decision rationale: There is documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for Assistant Surgeon is medically necessary.

LSO Back Brace: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 138-139.

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, Discectomy/laminectomy.

Decision rationale: There is documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for LSO Back Brace is medically necessary.