

Case Number:	CM14-0027082		
Date Assigned:	06/16/2014	Date of Injury:	01/30/2012
Decision Date:	10/23/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	03/03/2014

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:

This is a 28 year old male with a 1/30/12 injury date. The mechanism of injury was not provided. In a follow-up on 1/23/14, subjective findings included severe low back pain and left greater than right leg pain. Objective findings included use of a cane, limited lumbar motion, 5-/5 strength bilateral iliopsoas, quads, hamstrings, 4/5 strength left anterior tibialis, EHL, 4+/5 strength right anterior tibialis, EHL, and 4/5 strength gastrocnemius. Sensation was diminished to bilateral S1 and left L5 dermatomes. A lumbar spine MRI on 2/28/13 showed a 2 mm posterior disc protrusion at L4-5, and a 3-4 mm posterior disc protrusion at L5-S1 with bilateral neural foraminal stenosis. A more recent MRI (date not specified) showed progression of disc disease at L4-5 and L5-S1, and L5-S1 bilateral neural foraminal stenosis. An EMG/NCV on 6/26/13 was normal. Diagnostic impression: lumbar spondylosis, lumbar radiculopathy. Treatment to date: lumbar laminectomy (1/25/13), revision of lumbar decompression (5/2/13), epidural steroid injection, medications, physical therapy. A UR decision on 2/14/14 denied the request for L4-S1 posterior spinal fusion on the basis that there is no evidence of spinal instability. The request for orthopedic mattress was denied because evidence based guidelines do not support its use. The request for 2 day inpatient stay was denied because the surgical procedure was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar 4 through sacral 5 posterior spinal fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

Decision rationale: 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. However, in this case there is no evidence of spinal instability. There is no spondylolisthesis on MRI and there are no documented or discussed lumbar flexion/extension x-rays. The patient does have radiculopathy, but it is not clear how a spinal fusion would alleviate this above and beyond the benefits of a decompression. A psychological clearance was not obtained. Therefore, the request for LUMBAR 4 THROUGH SACRAL 5 POSTERIOR SPINAL FUSION is not medically necessary.

2 day inpatient stay: 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.

Orthopedic mattress: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

Decision rationale: CA MTUS does not address this issue. ODG states that mattress selection is not recommended. There are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Mattress selection is subjective and depends on personal preference and individual factors. However, the guidelines and evidence based literature does not support the use of orthopedic mattresses. Therefore, the request for orthopedic mattress is not medically necessary.