

Case Number:	CM14-0029811		
Date Assigned:	04/09/2014	Date of Injury:	06/14/2013
Decision Date:	08/14/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	01/27/2014

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 Pennsylvania and Maryland. 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 claimant is a 40 year old male who sustained a vocational injury on 06/14/13. The medical records provided for review documented that the claimant's working diagnosis was lumbar herniated disc. The report of the office visit dated 01/08/14 noted that physical therapy provided no relief and that an epidural steroid injection made his symptoms worse. Examination revealed that his plantarflexor and dorsiflexor were weak on the left side, rated at 4/5 compared to the right side of 5/5. The claimant could forward bend only about 30 degrees and extend with extension lag. The Waddell's sign was absent. The report of an MRI of the lumbar spine dated 07/26/13 showed at the L 4 level a posterior annular tear of the intervertebral disc with slight posterior central disc protrusion. There was a moderate sized left posterior lateral L 5 - S 1 disc herniation which effaced the left lateral recess and displaced the left S 1 nerve root at that level. Conservative treatments to date include anti-inflammatories, narcotics, Ultram, muscle relaxers, an epidural steroid injection, and formal physical therapy. The current request is for anterior posterior lumbar fusion and decompression at L4 - S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

ANTERIOR POSTERIOR LUMBAR FUSION & DECOMPRESSION L4-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the MTUS: American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, Chapter 12, Low Back Complaints, pages 305-307; and on the Non-MTUS: Official Disability Guidelines (ODG), Low Back chapter, Fusion (Spinal).

Decision rationale: The California MTUS ACOEM Guidelines, and supported by the Official Disability Guidelines, do not support the request for anterior posterior lumbar decompression and fusion L4-S1. The records do not identify any evidence of instability at the requested surgical levels. The ACOEM Guidelines only recommend fusion when there is fracture, dislocation or spondylolisthesis. There is a lack of documentation of the claimant's current smoking status. There is a lack of documentation that the claimant has had psychosocial screening. Therefore, based on the documentation presented for review and in accordance with the California MTUS ACOEM and Official Disability Guidelines, the request for the anterior posterior lumbar fusion decompression L 4-S 1 is not medically necessary.

TWO (2) DAY INPATIENT STAY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)- LOW BACK, HOSPITAL LENGTH OF STAY.

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.