

Case Number:	CM14-0044286		
Date Assigned:	06/20/2014	Date of Injury:	08/09/2012
Decision Date:	07/24/2014	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	03/19/2014

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 Texas. 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 injured worker is a 59 year old male who sustained an injury on 08/09/12. No specific mechanism of injury was noted. The injured worker was followed for ongoing chronic low back pain stemming from old L5-S1 lumbar fusion performed in the remote past. The injured worker also had laminectomy defects at L5. The injured worker was being followed by a treating physician. Magnetic resonance imaging of the lumbar spine from 11/27/13 noted an irregular osseous signal abnormality involving the right pars interarticularis of L4. There were metallic hardware devices traversing the anterior facets of L4. Mild biconcave compression deformities involving the L2 to L4 vertebral bodies were noted. Mild disc desiccation throughout the lumbar spine was identified. There was mild spondylitic change at L5-S1. By level there was a moderate diffuse disc herniation at L2-3 and L3-4 and to a lesser extent at L4-5. There was moderate canal stenosis from L2 to L4 and milder stenosis in the spinal canal at L4-5. There was lateral recess stenosis with deviation of the bilateral L2 and L3 nerve roots due to spondylitic disease. There was contract of the bilateral L4 nerve roots. The injured worker continued with pain management. Several strong narcotics including fentanyl and Norco were being prescribed to the injured worker. The injured worker was also followed for significant depression and anxiety symptoms and was being treated with psychotropics. The clinical record on 02/20/14 noted continuing painful and limited range of motion of the lumbar spine with positive straight leg raise findings at 50 degrees bilaterally. Motor weakness was noted in the lower extremities with no specific distribution. There was evidence of motor muscle atrophy. The injured worker was recommended for further wide decompression of the lumbar spine at L3-4 and L4-5 followed by anterior and posterior lumbar fusion. The request for anterior and posterior lumbar fusion at L3-4 and L4-5 with extension of fusion was denied by utilization review on 03/11/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior and Posterior Lumbar Fusion at the L3-L4 and L4-L5 levels with Extension of Fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The injured worker was followed for ongoing chronic low back pain radiating to the lower extremities and appeared to follow L3 through L5 distribution. Motor weakness was reported by the treating physician but dermatomal or myotomal findings were not identified. The injured worker had bilateral straight leg raise signs on physical examination. Magnetic resonance imaging (MRI) of the lumbar spine noted significant amount of spondylitic degenerative disc disease at L2-3, L3-4 and L4-5. There appeared to be some hardware extension up to L4 based on MRI. There was osseous signal abnormality of the right pars interarticularis at L4. It was unclear whether the pain generators had been adequately identified given the multilevel degenerative findings from L2 to L5. The records did not contain a pre-operative psychological evaluation ruling out any confounding issues for post-operative recovery. This was recommended and would have been indicated in this case due to the noted continuing depression and anxiety conditions that had been treated with psychotropics. In review of the clinical documentation provided anterior and posterior lumbar fusion at the L3-L4 and L4-L5 levels with extension of fusion is not medically necessary and appropriate.