

Case Number:	CM14-0050806		
Date Assigned:	07/07/2014	Date of Injury:	11/10/2003
Decision Date:	08/21/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/18/2014

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:

The injured worker is a 61-year-old male who reported injury on 11/10/2003. The mechanism of injury was not provided. The documentation of 09/18/2013 revealed the injured worker was getting shooting pain down the right greater than left leg posteriorly to the ankle. The injured worker was noted to have intermittent paresthesias, right worse than left. The documentation indicated prior treatments included physical therapy and epidural steroid injections. The surgical history was non-contributory. The physical examination revealed the injured worker's strength was 5/5 in the lower extremities and sensation was intact throughout. Deep tendon reflexes were 2+ at the ankles and knees bilaterally equal and symmetrical. Toes were downgoing. The straight leg raise was negative. The documentation indicated the injured worker underwent an MRI on 06/24/2013 which revealed at the level of L5-S1, there was severe degenerative disc disease with herniated nucleus pulposus and bilateral nerve root compression. Additionally, the injured worker had a mild to moderate degenerative disc disease at L4-5. The treatment plan included a right L5-S1 posterolateral oblique arthrodesis with posterolateral fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L5-S1 Posterolateral Oblique Arthrodesis W/Posterolateral Fusion: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Low Back.

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

Decision rationale: The ACOEM Guidelines indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise. There was neural compromise. There should be documentation of activity and limitations due to radiating leg pain for more than 1 month, clear clinical, imaging and electrophysiologic evidence of a lesion and documentation of failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the injured worker had undergone physical therapy and epidural steroid injections with no relief. There was a lack of documentation indicating the injured worker had clear clinical and electrophysiologic evidence of a lesion. The clinical documentation submitted for review per the physician documentation indicated the injured worker had findings upon imaging. However, the imaging was not provided for review. Additionally, there were no myotomal or dermatomal deficits documented to support the necessity for surgical intervention. Given the above, the request for right L5-S1 posterolateral oblique arthrodesis with posterolateral fusion is not medically necessary.

Bone Stimlator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Low Back.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation and is not medically necessary, the requested ancillary service is also not supported and is not medically necessary.