

Case Number:	CM14-0077826		
Date Assigned:	07/18/2014	Date of Injury:	11/18/2010
Decision Date:	08/25/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	05/27/2014

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 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 patient is a 50 year old female who was injured on 11/18/2010, when she twisted her back. She is diagnosed with lumbar disc disease, lumbar stenosis, spondylolisthesis, and radiculopathy. Her past medical treatment has included medications, chiropractic treatment, 12 physical therapy visits attended 1/15/2014 through 3/14/2014, and bilateral sacroiliac joint and right L4-5 facet joint injections on 11/21/2013. X-rays of the lumbar spin on 8/12/2012 showed mild L4-5 degenerative changes. Electrodiagnostic report on 4/11/2014 identified impaired conduction - class III fibers - ratings: left L1 upper lumbar nerve +2 moderate; left L2 lateral femoral cutaneous nerve +1 mild; hyper conduction - class III fibers (probable irritation): right S1 sural nerve -1 hyper. The patient had an orthopedic surgeon follow up on 4/4/2014, with complaints of continued lower back pain with pain radiating into the posterior aspect of the bilateral thighs. Her back pain is rated 7/10. She is currently taking Gabapentin 600 mg at night. On physical examination, there is muscle spasm on palpation next to the spinous processes and flexion and extension are limited due to pain. Muscle strength is 4/5 in the bilateral Extensor Hallucis Longus and otherwise 5/5 in the lower extremities bilaterally. Sensation is diminished bilaterally over the lateral calves. Reflexes are 2+ in the patellar and 1+ in the Achilles bilaterally. Straight Leg Raise above 50 degrees is negative, Fabere and Lasegue tests are also negative. Reportedly, a 4/09/2013 lumbar MRI demonstrated L4-5 spondylolisthesis with lateral recess stenosis. The physician states the patient's grade 1 spondylolisthesis was exacerbated due to an injury while twisting her back. Recommendation and requests are made for L4-5 lumbar fusion with instrumentation, co-surgeon, pre-operative clearance, post op rehabilitation x 12 sessions, DMEs, and home care and transportation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Lumbar Interbody Fusion at L4-5 and Lumbar Laminectomy at L4-5 with Instrumentation, Assistant Surgeon, Pre-Operative Medical Clearance, and 12 Post-Operative Physical Therapy Visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)Low Back, Spinal Fusion.

Decision rationale: According to the 4/4/2014 medical report, the patient has a grade 1 spondylolisthesis. According to the guidelines, spinal fusion in the absence of fracture, dislocation, unstable spondylolisthesis, tumor or infections, is not supported. However, the medical records do not establish spinal instability involving the L4-5 level, to warrant consideration of fusion. In addition, the medical records do not provide diagnostic evidence of a clear surgical lesion. Furthermore, the medical records do not establish that all the pre-operative indications recommended have been met and addressed, including psychosocial screen with confounding issues addressed. The medical records do not establish the patient is a candidate for the proposed lumbar fusion procedure. Medical necessity of the requested lumbar fusion has not been established, and so all other related requests are also not medically necessary.