

Case Number:	CM14-0088773		
Date Assigned:	07/23/2014	Date of Injury:	02/15/2012
Decision Date:	08/27/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/13/2014

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 Nevada. 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 records, presented for review, indicate that this 52-year-old male was reportedly injured on 2/15/2012. The mechanism of injury was noted as a fall. The most recent progress note, dated 5/6/2014, indicated that there were ongoing complaints of low back pain with pain radiating into the right lower extremity. The physical examination demonstrated cervical spine positive tenderness to palpation right greater than left with tenderness to the trapezius, positive tenderness palpation of the left upper extremity at the anterior glenohumeral aspect of the shoulder as well as subacromial area, right shoulder positive tenderness to palpation at the anterior glenohumeral area as well as subacromial area. A mild degree of muscular atrophy was present about the right shoulder girdle. Grip strength was diminished on the right side. Bilateral shoulders had decreased range of motion with pain. Lumbar spine had bilaterally weak heel and toe walk right greater than left. There was positive tenderness to palpation in the buttocks, lumbosacral junction right and left paralumbar areas. Positive straight leg raise on the right was at 70 on the left and 80 in a seated position. Supine was noted as the right side at 45 and left side at 80. Decreased sensation to the dorsal aspect of the right foot and lateral aspect of right calf. No recent diagnostic studies were available for review. Previous treatment included previous surgery, physical therapy, epidural steroid injections, and medication. A request had been made for lumbar decompression at L5-S1, posterior L5-S1 fusion, placement of a TLIFT and was not certified in the pre-authorization process on 6/9/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Decompression at L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: Lumbar discectomy is moderately recommended as an effective operation to speed recovery in patients with radiculopathy due to ongoing nerve root compression who continue to have significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. After review of the medical records provided, it was noted that the most recent diagnostic study was greater than 18 months old and did not reveal neural decompression. Therefore, the request for this procedure is deemed not medically necessary.

Posterior L5-S1 fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: ACOEM practice guidelines do not support a spinal fusion in the absence of fracture, dislocation, spondylolisthesis, instability or evidence of tumor/infection. Review of the available medical records documented a diagnosis of lumbar radiculopathy but failed to demonstrate any of the criteria for a lumbar fusion. Furthermore, there were no flexion/extension plain radiographs of the lumbar spine demonstrating instability and no documentation of lumbar epidural steroid injections. Given the lack of documentation, this request is not considered medically necessary.

Placement of a T-Lift: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Section.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: ACOEM practice guidelines do not support a spinal fusion in the absence of fracture, dislocation, spondylolisthesis, instability or evidence of tumor/infection. Review of the available medical records documented a diagnosis of lumbar radiculopathy but failed to demonstrate any of the criteria for a lumbar fusion. Furthermore, there were no flexion/extension plain radiographs of the lumbar spine demonstrating instability and no documentation of lumbar epidural steroid injections. Given the lack of documentation, this request is not considered medically necessary.