

Case Number:	CM14-0099495		
Date Assigned:	07/28/2014	Date of Injury:	08/17/2013
Decision Date:	09/29/2014	UR Denial Date:	06/14/2014
Priority:	Standard	Application Received:	06/27/2014

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:

This is a 35 year old female with a 8/17/13 injury date. She was carrying a 5 pound can of paint when she injured her lower back. In a follow-up on 1/24/14, subjective complaints include low back pain with radiation to the right leg, ankle, and top of the foot, and associated numbness and tingling. Objective findings include weakness in the right gastrocnemius, extensor hallucis longus (EHL), and anterior tibialis. Reflexes were normal and symmetric. There was a positive SLR test on the right side at 30 degrees. An EMG of the right lower extremity on 3/14/14 was normal, although "consistent with abnormalities involving the right L5 and S1 nerve roots." An MRI of the lumbar spine on 4/24/14 showed a 4 mm central disc protrusion at T11-12, mild central canal stenosis at L1-2, normal discs at L2-5, a 4 mm disc bulge at L5-S1 with mild narrowing of central canal and foramina bilaterally, previous left L5 hemilaminectomy, and 2 mm retrolisthesis of L5-S1. An MRI of the lumbar spine on 8/12/13 is relatively similar except that it notes that the L5-S1 disc bulge is contacting the right S1 nerve root. Diagnostic impression: lumbar degenerative disc disease, lumbar spondylolisthesis, lumbar radiculopathy. Treatment to date: physical therapy, acupuncture, epidural steroid injection, and medications, lumbar L5-S1 decompression (2008) which produced relief for 2 years. A UR decision on 6/13/14 denied the request for L5-S1 ant/post lumbar interbody fusion on the basis that there was no documented evidence of spinal instability or neural compression.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 anterior/ posterior lumbar decompression with interbody instrumented fusion:
Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Pages 305-308.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

Decision rationale: CA MTUS states that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair; and failure of conservative treatment. In addition, CA MTUS states that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. In the present case, the patient has evidence of spinal instability on MRI with 2 mm L5-S1 spondylolisthesis. Further support of instability at this level is the fact that the patient had prior lumbar decompression and discectomy at this level without fusion in 2008. There is also reasonable agreement between clinical exam findings, imaging findings, and EMG findings with respect to the right lower extremity radiculopathy. There is 4/5 weakness in muscles supplied by the L5 and S1 nerve roots as well as a positive SLR on the right side. The EMG was in agreement with this in that there was evidence of right L5 and S1 nerve root dysfunction in the absence of frank neuropathy. In addition, the MRI from 8/12/13 showed right S1 nerve root abutment against the disc bulge at L5-S1. Given all of these findings as a whole, there appears to be enough evidence to justify reversing the prior UR decision. Therefore, the request for L5-S1 anterior/ posterior lumbar decompression with interbody instrumented fusion is medically necessary.

2 day inpatient stay: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Low Back Chapter; Hospital Length of Stay.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

Decision rationale: CA MTUS does not address this issue. ODG cites a recommended post-op length of stay of 3 days after anterior or posterior lumbar fusion. The proposal of a 2 day inpatient stay is within the limits of these recommendations. Therefore, the request for 2 day inpatient stay is medically necessary.

