

Case Number:	CM14-0120223		
Date Assigned:	08/06/2014	Date of Injury:	10/09/2013
Decision Date:	01/23/2015	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	07/30/2014

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 37 year old male with a 10/9/13 injury date. The mechanism of injury was described as driving his forklift over a pothole. In a 6/17/14 note, the patient complained of lower back pain with bilateral lower extremity radiation, with episodes of numbness and tingling. The pain level has range from 4-7/10 and awakens him at night. Objective findings included lumbar spasms, tenderness over the lumbar musculature, positive straight leg raising bilaterally at 35 degrees, diminished sensation over the posterior calf, and 4/5 strength in the bilateral tibialis anterior, extensor hallucis longus, and gastrocnemius. Lumbar flexion/extension x-rays on 6/17/14 revealed L5-S1 retrolisthesis with motion. A 12/5/13 lumbar MRI revealed degenerative disc disease at L4-5 and L5-S1 with significant disc bulging, central canal stenosis, facet arthropathy, and neural foraminal stenosis. The provider recommended a 360 degree anterior/posterior lumbar fusion because the patient has a failing motion segment with instability. It was believed that addressing either column alone would be insufficient and would result in a high likelihood of additional surgery in the future. Diagnostic impression: lumbar spondylosis and radiculopathy. Treatment to date: physical therapy, work restrictions, chiropractic care, epidural steroid injection, medications. A UR decision on 7/21/14 denied the request for L4-S1 lumbar fusion and decompression because the extent of the retrolisthesis on the lumbar flexion/extension x-rays was not outlined by the provider. The requests for inpatient stay and assistant surgeon were denied because the associated surgical procedure was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient anterior posterior fusion and decompression at L4-S1 with assistant surgeon w/2 day LOS: Overturned

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

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--Hospital length of stay and on Other Medical Treatment Guideline or Medical Evidence: American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics

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 this case, there appear to be sufficient evidence and support for the requested procedure. The patient has objective signs of radiculopathy on both exam and imaging that are well-correlated. In addition, there is evidence of spinal instability on lumbar flexion/extension x-rays. In addition, the patient has failed a substantial amount of conservative treatment in the past. ODG supports a 3-day inpatient stay after lumbar fusion procedures. The AAOS states that the use of an assistant surgeon is ultimately under the discretion of the operating surgeon. Therefore, the request for inpatient anterior posterior fusion and decompression at L4-S1 with assistant surgeon w/2 day LOS is medically necessary.