

Case Number:	CM14-0186614		
Date Assigned:	11/14/2014	Date of Injury:	04/30/2000
Decision Date:	01/06/2015	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	11/10/2014

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 Spine Surgeon and is licensed to practice in Texas. 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 62-year-old male who reported an injury of unspecified mechanism on 04/30/2000. On 10/22/2014, his diagnoses included lumbago, displacement of lumbar intervertebral disc without myelopathy, degeneration of lumbar or lumbosacral intervertebral disc and sprain/strain of the lumbar region. On 08/18/2014, his complaints included low back pain radiating into the left lateral calf and foot. He rated his pain 7-9/10. His previous treatments included physical therapy, home exercise and activity modification. His medications included terazosin, Norco, and Neurontin at unspecified dosages. Upon examination, he had tenderness at the left sciatic notch and lumbosacral area. He underwent a spinal fusion at L5-S1 in 2001. An MRI from 08/19/2013 revealed a solid fusion at L5-S1 and mild joint DJD (degenerative joint disease) with lateral recess and foraminal narrowing at L4-5. He was assessed to have degeneration with stenosis at L4-5. He felt that the instrumentation from the prior surgery was causing some of his back pain and wanted the instrumentation removed. On 10/22/2014, he reported that the numbness and left leg pain were his worst symptoms. Treatment options were discussed and he chose to have an epidural steroid injection to determine whether or not L4-5 decompression was necessary at the time of surgery. There was no subsequent documentation submitted for review. The rationale for the proposed surgery included the FDA recommendation regarding the use of pedicle screws and their subsequent removal after fusion had occurred. There was no Request for Authorization included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decompression of the spinal stenosis at L4-5 combined with removal of the instrumentation with exploration of the fusion: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Chapter: Spinal Fusion

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

Decision rationale: The California ACOEM Guidelines note that within the first 3 months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction, not responsive to conservative therapy, and obviously due to a herniated disc, is detected. Referral for surgical consultation is indicated for patients who have: severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies including radiculopathy, preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than 1 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 to resolve disabling radicular symptoms. This injured worker had participated in elements of conservative care consisting of physical therapy, activity modification, and a home exercise program. There was no submitted documentation that he had participated in acupuncture, chiropractic treatments or failed trials of antidepressants. An epidural steroid injection was recommended and agreed to by this injured worker, but there was no subsequent documentation regarding the performance of this procedure, or any results therefrom. The clinical information submitted failed to meet the evidence based guidelines for the proposed surgery. Therefore, the request for decompression of the spinal stenosis at L4-5 combined with removal of the instrumentation with exploration of the fusion is not medically necessary.