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| Case Number: | CM14-0192293 | | |
| Date Assigned: | 11/26/2014 | Date of Injury: | 01/30/2013 |
| Decision Date: | 01/12/2015 | UR Denial Date: | 11/11/2014 |
| Priority: | Standard | Application Received: | 11/18/2014 |

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 Surgery 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 60 year old female with a date of injury as 01/30/2013. The worker slipped and fell at work landing on her right side, and her left leg twisted and forcefully struck the floor. The current diagnoses grade I spondylolisthesis at L4-L5 and spinal stenosis. Previous treatments include physical therapy, oral medications, fluid removal from the knee and injection in the knee. Physician reports dated 08/20/2013 and 01/10/2014, and Magnetic Resonance Imaging (MRI) of the lumbar spine dated 07/11/2013 were included in the documentation submitted. The Magnetic Resonance Imaging (MRI) showed mild disk desiccation with minimal grade I spondylolisthesis at L4-L5, associated with moderate degenerative changes involving the L4-L5 apophyseal joints bilaterally, resulting in mild to moderate spinal stenosis and mild bilateral foraminal narrowing. Mild disk desiccation with a central bulge at the T12-L1 level, no nerve root compression was identified. Report dated 01/10/2014 noted that the injured worker presented with complaints of worsening back pain with right leg pain, numbness and tingling. She stated that the physical therapy is not helping her back pain. Physical examination revealed lumbar paraspinous muscle spasms, tenderness to palpation, straight leg raise was negative bilaterally, motor strength was normal, and deep tendon reflexes were within normal limits. The provider noted that he felt that the injured worker has reached maximum medical benefit from conservative treatment and is now a surgical candidate. The physician felt that the injured worker is a candidate for lumbar spine posterior interbody fusion L4-L5. The injured workers work status at the time of this report was temporarily totally disabled but could return to modified duties as of 01/07/2014 unless her pain became more severe. The utilization review performed on 11/11/2014 non-certified a request for lumbar spine posterior interbody fusion L4-L5 based on no evidence of instability. The reviewer referenced the California MTUS and ACOEM.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spine posterior interbody fusion L4-5 level with 3 day inpatient hospital stay:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 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, Hospital Length of Stay

Decision rationale: The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and 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 documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, 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. There would not need to be documentation of electrophysiologic evidence. The injured worker had grade 1 spondylolisthesis at L4-5. There was no x-ray with extension and flexion views to support spinal instability. There was a lack of documentation of an objective physical examination to reveal clear clinical evidence of instability. As such, the interbody fusion would not be supported. The Official Disability Guidelines indicate that the median stay for an interbody fusion is 3 days. This portion of the request would be supported if the request itself were supported. Given the above, the request for lumbar spine posterior interbody fusion L4-5 level with 3 day inpatient hospital stay is not medically necessary.