

Case Number:	CM14-0194579		
Date Assigned:	12/02/2014	Date of Injury:	07/31/2000
Decision Date:	01/14/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	11/19/2014

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 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:

The injured worker is a 73-year-old male who reported an injury on 07/31/2000. The mechanism of injury was not provided. The injured worker was noted to undergo prior treatments including pain medications, transcutaneous electrical nerve stimulation, and an epidural steroid injection at L4-5. The surgical history included a decompression surgery at L3-5 for spinal stenosis and an L5-S1 fusion. The documentation of 06/13/2014 revealed the injured worker had left lower extremity and bilateral arm numbness and neck pain. The injured worker was noted to have received a transforaminal injection at L4-5 which gave 2 weeks of almost complete relief. The injured worker indicated over the last 2 to 3 years he had a progressive loss of balance and difficulty with gait. The injured worker had no incontinence of bowel or bladder. The injured worker had no new weakness since the last visit. The physical examination revealed the injured worker was utilizing a cane. The injured worker was unable to walk on his toes and heels. The injured worker indicated flexing forward gave him some relief in the cervical spine. The evaluation of the bilateral lower extremities revealed motor strength intact; however, the injured worker had a positive straight leg raise with radiating pain shooting over from the buttock down to the leg. Evaluation of the injured worker's back revealed him to have some increasing pain in flexion versus extension, and the injured worker was noted to have constant pain over the back. The documentation indicated the injured worker underwent an MRI which revealed at L4-5, there was foraminal stenosis and degenerative disc disease with a loss of disc height. The diagnosis was spondylolisthesis and left leg radiculopathy, and the recommendation was for an L4-5 transforaminal lumbar interbody fusion. Medications included Gabapentin 300 mg take 4 capsules by mouth 3 times a day, Colace 250 mg 1 capsule twice a day, Atrovent inhalation, Aspirin 81 mg, Pradaxa 150 mg twice a day, Lipitor 10 mg 1 tablet daily, Lisinopril 20 mg

tablets 1 daily and Hydrocodone 10/325 mg 1 to 2 tablets every 6 hours as needed. No Request for Authorization submitted for review for the requested interbody fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal laminectomy decompression with instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

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

Decision rationale: The ACOEM Practice Guidelines 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. The clinical documentation submitted for review indicated the injured worker had MRI findings but the MRI was not provided for review. The physical examination revealed the injured worker had a positive straight leg raise with radiating pain shooting from the buttock down the leg. There was a lack of documentation of a failure of conservative care. The injured worker had a diagnosis of spondylolisthesis; however, the diagnosis was not substantiated. There was a lack of documentation of flexion and extension studies with documented instability. Additionally, the request as submitted failed to indicate the levels to be treated with surgical intervention. Given the above, the request for spinal laminectomy decompression with instrumentation is not medically necessary.

Associated surgical service: Hip ICBG harvest: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar and Thoracic

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

