

Case Number:	CM14-0209946		
Date Assigned:	12/22/2014	Date of Injury:	07/11/2014
Decision Date:	02/23/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 47-year-old male who reported injury on 07/11/2014. The mechanism of injury was due to lifting a table and injuring his back. The injured worker has a diagnosis of lumbar sprain. Past medical treatment consists of ice, physical therapy, inversion therapy, chiropractic therapy, and medication therapy. Medications consist of tramadol, acetaminophen, gabapentin, tizanidine, and ibuprofen. An MRI obtained on 08/20/2014 showed L4-5 with moderate degenerative disc disease with a right herniated nucleus pulposus and nerve root compression. On 11/17/2014, the injured worker complained of constant, sharp pain in the lower back. Physical examination of the back revealed no tenderness to palpation. There was decreased range of motion. Strength was 5/5 in the lower extremities bilaterally and sensation was intact throughout. Deep tendon reflexes were "3-4+" at the ankle and knees bilaterally, equal and symmetric. There was no clonus. Straight leg raise was negative bilaterally. The provider feels that the injured worker is a surgical candidate. Rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L4/5 posterior oblique lumbar arthrodesis with posterolateral fusion and instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: The request for right L4/5 posterior oblique lumbar arthrodesis with posterolateral fusion and instrumentation is not medically necessary. The MTUS/ACOEM Guidelines do not recommend spinal fusion except in cases of trauma related to spinal fracture dislocation. Fusion of the spine is not usually considered during the first 3 months of symptoms. Surgical guideline considerations consist of severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, activity limitations due to radiating leg pain for more than 1 month, clear clinical imaging and electrophysiologic evidence of a lesion that has been shown to be beneficial from the short term and long term surgical repair, failure of conservative treatment and indication of psychological screening. The submitted documentation indicated that the injured worker complained of constant low back pain with numbness and tingling. Examination of the lumbar spine revealed that there was no tenderness to palpation of the back. There was decreased range of motion. There was a strength of 5/5 in the lower extremities bilaterally and sensation was intact throughout. Straight leg raise was negative bilaterally. An MRI of the lumbar spine revealed L4-5 moderate degenerative disc disease with a right herniated nucleus pulposus and nerve root compression. However, there was no evidence as to failure of conservative treatment. Additionally, there were no functional deficits documented upon physical examination of the injured worker's lower back. Furthermore, the guidelines do not recommend spinal fusion unless there is evidence of spinal fracture or dislocation. There was no evidence of diagnosis submitted for review congruent with the above. Given the above, the injured worker is not within guideline criteria. As such, the request is not medically necessary.

Bone stimulator; TLSO brace: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.