

Case Number:	CM15-0001599		
Date Assigned:	01/14/2015	Date of Injury:	04/21/2009
Decision Date:	03/27/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	01/05/2015

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: Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 48-year-old male who reported an injury on 04/21/2009. The mechanism of injury was not specifically stated. The current diagnoses include cervical sprain/strain, left wrist sprain/strain, left carpal tunnel syndrome, history of trigger thumb, acute thoracic sprain, lumbosacral sprain, hip complaints, fracture of the left 5th toe, status post left carpometacarpal interposition arthroplasty, fracture of the left fifth metatarsal, left first carpometacarpal arthritis, and chronic left forearm pain. The injured worker presented on 11/10/2014 for an orthopedic spine re-evaluation. Upon examination of the lumbar spine, there was tenderness to palpation from the L3-S1 level, moderate to moderately severe paraspinal muscle guarding with tenderness, moderate left slight sciatic notch tenderness and right sciatic notch tenderness, 30 degree flexion, 5 degree extension, 10 degree right and left lateral bending, hypesthesia in the lateral aspect of the left foot, weakness of the left great toe extensor, trace ankle reflexes on the left, and mildly positive sciatic stretch test on the left. There was positive straight leg raising bilaterally at 60 degrees on the left and 70 degrees on the right. Recommendations included a decompressive laminectomy and discectomy at L3-S1 with posterolateral fusion, bone graft, pedicle screw fixation, and posterior interbody fusion with implants. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decompressive laminectomy and discectomy (L3-4, L4-5, L5-S1): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Discectomy/Laminectomy.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines recommend a discectomy/laminectomy when there is objective evidence of radiculopathy upon examination. Imaging studies should reveal nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment should include activity modification, drug therapy, and epidural steroid injection. There should also be evidence of a referral to physical therapy, manual therapy, or the completion of a psychosocial screening. In this case, there is documentation of neural foraminal narrowing at L3-S1 with objective evidence of diminished reflexes, hypesthesia, and weakness in the left lower extremity. However, there was no documentation of a recent attempt at any conservative treatment to include epidural steroid injection and active rehabilitation. Therefore, the current request cannot be determined as medically appropriate at this time.

Posterolateral fusion: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (spinal).

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. There was no documentation of spinal instability upon flexion and extension view radiographs. There was also no documentation of a psychosocial screening completed prior to the request for a lumbar fusion. Given the above, the request is not medically appropriate.

Bone graft: 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.

Pedicle: 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.