

Case Number:	CM15-0161339		
Date Assigned:	08/28/2015	Date of Injury:	09/23/2014
Decision Date:	10/08/2015	UR Denial Date:	08/03/2015
Priority:	Standard	Application Received:	08/18/2015

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: Minnesota, Florida
 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 50 year old male who sustained an industrial injury on 09-23-2014. Mechanism of injury occurred when he was pulling a tree root out and it tore off and he fell backwards and landed on his back. Diagnoses include lumbar stenosis, lumbar radiculopathy, lumbar disc displacement, and severe foraminal facet arthropathy. Treatment to date has included diagnostic studies, medications, physical therapy, application of heat and gentle massage, home stretching, use of a cane, and epidural steroid injections. He takes Vicodin as needed. A report of a lumbar Magnetic Resonance Imaging done on 12-24-2014 shows significant foraminal stenosis at L4-L5, which is moderate to severe. There is a 3.5mm disc herniation at L5-S1. A physician progress note dated 07-16-2015 documents the injured worker complains of intermittently continued lumbar spine pain that radiates to the right lower extremity. There is moderate discomfort with palpation of the mid-lumbar spine. There is diminished perception of light touch at the bottom of the right foot. He ambulates with a cane. Treatment requested is for Transforaminal lumbar interbody fusion L4-S1, Surgery assistant, physician assistant, Associated surgical service: inpatient stay for 3 days, Associated surgical service: external bone growth stimulator, and Associated surgical service: ASPEN LSO (Lumbosacral Orthotic Back) lumbar brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal lumbar interbody fusion L4-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 306, 307 and 310.

Decision rationale: The injured worker complains of low back pain with some radiation down the right lower extremity with numbness and tingling. The MRI scan of the lumbar spine dated 12/24/2014 revealed the following impression: 1. from the levels of L3-4 through L5-S1 there is facet hypertrophy and varying degrees of foraminal impingement and central canal decompression. 2. This appears most marked at the levels of L4-5 and L5-S1 where there is marked to severe bilateral foraminal impingement and mild central canal compression. 3. At the level of L5-S1 there is also disc desiccation and an associated 3.5 mm central posterior disc bulge. 4. Minimal degenerative spurring is noted anteriorly involving L2-L5 vertebral bodies. Progress notes dated 4/28/2015 indicate no relief from an epidural steroid injection. A subsequent progress note of 5/13/2015 indicates that the injection helped for 1-2 days. Another progress note dated 6/24/2015 indicates continuing complaint of pain in the low back. He did not feel much relief from the epidural steroid injection. A subsequent progress note dated July 16, 2015 indicates 75% pain relief from another injection of 6/23/2015. The California MTUS guidelines recommend surgical considerations for severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one 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. Before referral for surgery psychological screening is recommended. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. 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. In this case, there is no documentation of degenerative spondylolisthesis and there is no instability. A psychological evaluation has not been carried out. The pain is in the right lower back with some radiation but there is no disabling lower leg pain. As such, the request for a lumbar fusion is not supported and the medical necessity of the request has not been substantiated.

Associated surgical service: inpatient stay for 3 days: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Surgery assistant, physician assistant: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated surgical service: ASPEN LSO (Lumbosacral Orthotic Back) lumbar 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated surgical service: external bone growth stimulator: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.