

Case Number:	CM15-0199543		
Date Assigned:	10/14/2015	Date of Injury:	05/03/2013
Decision Date:	12/04/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	10/09/2015

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: New York, Montana, California
 Certification(s)/Specialty: Neurological 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 47 year old male with an industrial injury date of 05-03-2013. Medical record review indicates he is being treated for lumbar spondylolisthesis, lumbar bilateral micro-instability and lumbar disc displacement with radiculopathy. Subjective complaints (09-10-2015) included back and leg pain, bilateral buttocks and thigh and calf pain. "He is unable to work." Prior treatment included "multiple sessions of physical therapy" and medications. Prior diagnostics are documented as: CT of lumbar spine (06-05-2015) is documented as showing bilateral pars defects at lumbar 4-lumbar 5 without significant spondylolisthesis (seen as described.) There were mid annular disk bulges at lumbar 4-lumbar 5 and lumbar 5-sacral 1. The neural foramina appear preserved at all levels. MRI of the lumbar spine (03-28-2014) is documented as showing lumbar 2-lumbar 3 2 mm posterior disc bulge without evidence of canal stenosis or neural foraminal narrowing. Lumbar 4-lumbar 5 1-2 mm posterior disc bulge and facet joint hypertrophy without evidence of canal stenosis or neural foraminal narrowing and lumbar 5-sacral 1 mild to moderate bilateral neural foraminal narrowing secondary to 2-3 mm posterior disc bulge and facet joint hypertrophy. Bilateral exiting nerve root compromise is seen. Physical exam findings (09-10-2015) included diffuse tenderness on palpation of the mid lumbar spine. There was back pain upon extension at 20 degree. Other findings included diminished perception to light touch of the lateral shin and anterior foot of the left lower extremity. Left dorsiflexion and plantar flexion strength was 4 out of 5. On 09-23-2015 the request for the following treatments was denied by utilization review: Transforaminal lumbar interbody fusion L4-5; Associated surgical service: Hospital stay (x 3) days- Associated surgical service: Assistant- Associated surgical service: Aspen LSO 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 L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for surgery-Discectomy/Laminectomy(http://www.odg-twc.com/odgtwc/low_back.htm#Fusion).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of these conditions. Documentation does not show evidence of disc herniation or instability. His magnetic resonance imaging scan (MRI) showed no severe canal or foraminal stenosis or nerve root impingement. His provider recommended a lumbar interbody arthrodesis to treat his lumbago and lumbosacral spondylosis. Documentation does not present evidence of instability or radiculopathy. According to the Guidelines for the performance of fusion procedures for degenerative diseases of the lumbar spine, published by the joint section of the American Association of Neurological surgeons and Congress of Neurological surgeons in 2005 there was no convincing medical evidence to support the routine use of lumbar fusion at the time of primary lumbar disc excision. This recommendation was not changed in the update of 2014. The update did note that fusion might be an option if there is evidence of spinal instability, chronic low back pain and severe degenerative changes. Moreover, this patient does not have disc herniation's that would mandate a discectomy. Documentation does not show instability or severe degenerative changes. The requested treatment Transforaminal lumbar interbody fusion L4-5 is not medically necessary and appropriate.

Associated surgical service: Hospital stay (x3) days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.odg-twc.com/odgtwc/low_back.htm#Fusion.

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.

Associated surgical service: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical service: Aspen LSO lumbar brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.odg-twc.com/odgtwc/low_back.htm.

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.