

Case Number:	CM14-0142746		
Date Assigned:	09/12/2014	Date of Injury:	10/20/2011
Decision Date:	10/17/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/03/2014

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 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 records, presented for review, indicate that this 48-year-old male was reportedly injured on October 20, 2011. The mechanism of injury was noted as a fall. The most recent progress note, dated August 13, 2014, indicated that there were ongoing complaints of low back pain with radiation into the left leg. The physical examination demonstrated an alert and oriented individual in no acute distress. The patient was with an antalgic gait and required use of a cane. The patient was unable to heel or toe walk. There was tenderness to palpation to the midline and left paraspinal regions of the lumbar spine, with decreased range of motion in all planes. Sensation was diminished at the left L3, L4, L5, and S1 dermatomes. Motor examination was decreased bilaterally but more so, on the left side. Straight leg raise test was positive on the left side. There was a positive Lasegue's maneuver on the left side. Diagnostic imaging studies included a CT of the lumbar spine from May 2014, which showed multilevel degenerative disc disease and facet arthropathy with retrolisthesis, as well as L4-L5 moderate canal stenosis, with moderate bilateral neural foraminal narrowing at L4-L5, with moderate to severe right and moderate left neural foraminal narrowing at L5-S1. An MRI of the lumbar spine from November 2013 showed presumed postoperative changes with degenerative disc changes, facet arthropathy and retrolisthesis at L4 through L5 with possible bilateral L5 spondylolysis, recommending CT correlation. There was focal protrusion seen at T12 through L1 with central canal stenosis. There was also neural foraminal narrowing, which was mild at left L2 through L3, mild to moderate at bilateral L4 through L5, and moderate at bilateral L5 through S1. Previous treatment included epidural steroid injections and medications. Requests have been made for microlumbar decompression surgery at L4-L5 on the left side, preoperative clearance with internal medicine, preoperative laboratories, a chest x-ray, and posterior spinal fusion with posterior lumbar

interbody fusion at L5-S1, and were not certified in the pre-authorization process on August 19, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Microlumbar decompression surgery at L4-L5 on the left side: Upheld

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

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

Decision rationale: ACOEM practice guidelines support a lumbar laminectomy/discectomy for the treatment of sub-acute and chronic radiculopathy due to ongoing nerve root compression who continue to have significant pain and functional limitation after 6 weeks of conservative treatment. Review of the available medical records, documents a diagnosis of chronic lumbar radiculopathy, but fails to document a failed trial of conservative treatment. In fact, previous treatment thus far has only included epidural steroid injections and medications. As such, this request is considered not medically necessary.

Pre operative clearance with internal medicine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Preoperative Evaluation; American Family Physician. 2000 July 15; 62(2): 396.

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

Pre-operative laboratories: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Preoperative Evaluation; American Family Physician. 2000 July 15; 62(2): 396.

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

Chest X-ray: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Preoperative Evaluation; American Family Physician. 2000 July 15; 62 (2): 396.

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

Posterior spinal fusion with posterior lumbar interbody fusion at L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307, 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Criteria for Lumbar Spinal Fusion

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

Decision rationale: ACOEM practice guidelines do not support a spinal fusion in the absence of fracture, dislocation, spondylolisthesis with instability or evidence of tumor/infection. Review of the available medical records documents a diagnosis of lumbar radiculopathy but fails to demonstrate any of the criteria for a lumbar fusion. Furthermore, there is no flexion/extension via plain radiographs of the lumbar spine demonstrating instability. And while there is documentation of lumbar epidural steroid injections, again, there is no documentation of criteria warranting a spinal fusion. Furthermore, there is no documentation of a failed trial of conservative therapy, such as physical therapy. Additionally, surgery increases the need for future surgical procedures with higher complication rates. As such, this request is not considered medically necessary.