

Case Number:	CM14-0160470		
Date Assigned:	10/06/2014	Date of Injury:	08/14/2007
Decision Date:	11/03/2014	UR Denial Date:	09/03/2014
Priority:	Standard	Application Received:	09/30/2014

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 Texas. 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 injured worker is a 62 year old male truck driver with a date of injury on 8/14/2007. His injury occurred when he missed a step coming down from his truck and fell backwards. Past medical history was positive for polio with left sided weakness and atrophy in the left leg, depression and anxiety, and obesity. Past surgical history was positive for anterior cervical fusion at C5/6. Conservative treatment has included physical therapy, anti-inflammatory medications, pain medications, and epidural steroid injections without sustained benefit. The 1/20/14 lower extremity nerve conduction study findings documented chronic severe motor axonal neuropathy of the left lower extremity compatible with a history of polio. He was unable to tolerate electromyogram of the lower extremities. The 5/15/14 treating physician report cited continued back pain and lower extremity numbness, tingling, and weakness. Difficulty was reported with standing and walking. Physical exam documented limited lumbar flexion/extension secondary to pain and mild paraspinal tenderness. Lower extremity exam documented atrophy throughout the left lower extremity secondary to polio, 4/5 extensor hallucis longus weakness bilaterally, and normal sensation. Straight leg raise testing was negative. Gait was normal. Lower extremity deep tendon reflexes were +2 and symmetrical at the patella, and +1 and symmetrical at the ankle. X-ray studies documented degenerative changes at L3/4, L4/5, and L5/S1 with disc space narrowing, worse at L4/5 and L5/S1. The 4/29/14 lumbar spine magnetic resonance imaging scan was reviewed. Findings demonstrated a very large synovial cyst at L4/5 causing significant compression upon the dural sac at this level and bilateral foraminal stenosis. There was a disc herniation at L5/S1 and facet changes with instability at L4/5 and L5/S1. There was a disc osteophyte at L3/4 with a disc bulge and mild compression upon the right exiting L3 nerve root. The injured worker had mechanical low back pain and instability of the lumbar spine documented by the facet changes at L4/5 and L5/S1. He had significant compression upon the

dural sleeve at L4/5 secondary to a large facet cyst. Given the on-going nature of his symptoms and the progressive nature of his neurologic dysfunction, surgical treatment was recommended. There was an authorization request for posterior lumbar decompression and fusion at L4/5 and L5/S1, and possibly L3/4. The 9/3/14 utilization review denied the request for lumbar surgery as there was no current imaging report available for review, radiographic evidence of instability, or indication for surgery at the levels of L3/4 or L5/S1. There was a history of depression and a psychological clearance would be required.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior lumbar decompression and fusion L4-5 and L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-311. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal)

Decision rationale: The American College of Occupational and Environmental Medicine guidelines recommend lumbar discectomy for workers with radiculopathy due to on-going nerve root compression who continue to have significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. The Official Disability Guidelines recommend criteria for lumbar decompression include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Fusion may be supported for surgically induced segmental instability but pre-operative guidelines recommend completion of all physical medicine and manual therapy interventions and psychosocial screen with all confounding issues addressed. Guideline criteria have not been met. There are reported imaging findings of a very large synovial cyst causing significant dural sac compression at L4/5 and facet joint changes with reported instability at L4/5 and L5/S1. The formal magnetic resonance imaging scan report is not available. Past medical history is positive for depression and psychological treatment. There is no documentation of psychological clearance as required by guidelines for fusion surgery. Therefore, this request is not medically necessary.

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

Post-op lumbar sacral 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.