

Case Number:	CM14-0170512		
Date Assigned:	10/20/2014	Date of Injury:	07/27/2007
Decision Date:	11/24/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	10/15/2014

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 Spine 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 53-year-old male who reported an injury 07/27/2014. The mechanism of injury was not provided. The injured worker's diagnoses included sprain of lumbar region, spinal enthesopathy, lumbago and unspecified thoracic/lumbar neuritis. The injured worker's past treatments included medications, physical therapy and epidural steroid injections. The injured worker's diagnostic testing included official echocardiogram performed on 03/21/2014, which indicated left ventricular hypertrophy, left atrial enlargement and mild mitral valve regurgitation; an official ultrasound of the carotids performed on 03/21/2014, which indicated normal duplex examination of the carotid bifurcation; an official MRI of the lumbar spine performed on 09/26/2013, which indicated diffuse annular bulges present at L2-3 and L3-4, L4-5 and L5-S1, which extended into neural foramina and more prominent in the lower lumbar levels, associated ligamenta flava hypertrophy and, in part, mild facet hypertrophy at L4-5 and L5-S1 contributing to mild to moderate acquired central canal stenosis; an official ultrasound of the abdomen performed on 06/02/2014, which indicated unremarkable abdominal ultrasound. The injured worker's surgical history included epidural steroid facet injections performed on 06/09/2014. On the clinical note dated 08/26/2014, the injured worker complained of low back pain, left and back of neck stabbing pain, and radiation and numbness to bilateral lower extremities. The injured worker states that the neck pain radiates down arms into the last 2 "fingers on both arms" with numbness. The injured worker rates his pain 7/10. The injured worker had range of motion to the lumbar spine, flexion at 25 degrees and extension at 10 degrees with pain, positive for bilateral lumbar spine triggers, and positive straight leg raise bilaterally at the L5-S1 dermatomes. The injured worker's gait was noted to be antalgic with a cane. The injured worker's medications include Norco and Anaprox; frequencies and dosages not provided. The request was for lumbar surgery and associated inpatient hospital stay. The

rationale was for L5-S1 fusion. The Request for Authorization form was submitted for review on 08/27/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgical service: L5-S1 posterior interbody decompression fusion, instrumentation allografting any repairs: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC): Low Back Procedure Summary last updated 08/22/2014

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion and Transplantation, intervertebral disc

Decision rationale: Request for surgical service: L5-S1 posterior interbody decompression fusion, instrumentation allografting any repairs is not medically necessary. The injured worker is diagnosed with lumbar sprain, spinal enthesopathy, lumbago and unspecified thoracic/lumbar neuritis. The California MTUS/ACOEM Guidelines do not recommend spinal fusion for chronic low back pain. The guidelines state, except for cases of trauma related spinal fracture or dislocation, fusion of the spine is not usually considered during the first 3 months of symptoms. 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. The Official Disability Guidelines do not recommend fusion for patients who have less than 6 months of failed recommended conservative care, unless there is objectively demonstrated severe structural instability and/or acute or progressive neurological dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise. The operative clinical surgical indications for spinal fusion should include all of the following: All pain generators are identified and treated; all physical medicine and manual therapy interventions are completed; x-rays demonstrating spinal instability and/or myelogram, CT myelogram or discography and MRI demonstrating disc pathology correlate with symptoms and exam findings; spine pathology limited to 2 levels; psychosocial screen with confounding issues addressed; if any potential fusion surgery is recommended, that the patient refrain from smoking for at least 6 weeks prior to surgery and during the period of fusion healing; the patient has greater than 6 months conservative care documentation to have failed; the patient is noted to have central canal stenosis at the requested level on MRI results. The Official Disability Guidelines do not recommend implantation of intervertebral disc until further research is completed. The request is for L5-S1 posterior interbody decompression fusion, instrumentation allografting any repairs, which the guidelines do not recommend allografting. As such, the request for surgical service: L5-S1 posterior interbody decompression fusion, instrumentation allografting any repairs is not medically necessary.

[REDACTED]: Hospital inpatient stay, QTY: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.