

Case Number:	CM14-0099308		
Date Assigned:	08/08/2014	Date of Injury:	06/28/1999
Decision Date:	09/17/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/27/2014

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 48-year-old male who reported injury on 06/28/1999. The mechanism of injury was not provided. The prior therapies were noted to include physical therapy, chiropractic treatment, injections, acupuncture, injections and medications. The injured worker's medications were noted to include oxycodone hydrochloride 40 mg, Maxalt 10 mg, Roxicodone 15 mg, Zanaflex 6 mg as needed, hydrocodone/acetaminophen and Ambien CR. The surgical history was not provided. The injured worker underwent an MRI of the lumbar spine on 10/18/2013, which revealed at the level L5-S1 the injured worker had a markedly narrow interspace showing a mild to moderate broad based disc protrusion measuring approximately 3.6 mm beyond the adjacent posterior vertebral body margins. There was effacement of the adjacent anterior thecal sac with mild bilateral facet arthropathy. The documentation of 05/30/2014, revealed the injured worker had extensive nonoperative treatment. The injured worker trialed additional injections, which had not helped. The injured worker's pain was around the belt line and would occasionally radiate into the lower extremities, right greater than left. It was noted to be especially bad with repetitive flexion type maneuvers. The surgical history was noncontributory. The physical examination revealed the injured worker had tenderness to palpation just left to the midline around L4-5 and L5-S1. The injured worker had 4+/5 weakness in the extensor hallucis longus bilaterally. The injured worker had decreased range of motion and flexed to approximately 20 degrees with increasing back and guarding extending to less than 5 degrees with guarding. The straight leg raises were negative. Sensation was grossly intact to light touch. The documentation indicated the injured worker underwent an x-ray of the lumbar spine, minimum 4 views. The diagnoses included lumbar disc herniation, stenosis, radiculopathy and segmental instability. The documentation indicated the injured worker had a severe collapse at the L5-S1 level with foraminal narrowing bilaterally. The recommendation was made for a

transforaminal interbody fusion and the L5-S1 segment. Additionally, the documentation indicated the injured worker was a smoker and the injured worker indicated he would do his best to quit. There was a Request for Authorization submitted for the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Lumbar Interbody Fusion At L5-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): 307-309.

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg systems in a distribution consistent with abnormalities on imaging, preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms. There should be 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 the failure of conservative treatment. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back pain in the absence of spinal fracture, dislocation or spondylolisthesis, if there is an instability and motion in the segment operated on. There would be no documentation to include an electrodiagnostic study as that is not applicable for an interbody fusion. The clinical documentation submitted for review indicated the injured worker had objective findings upon MRI of mild spondylosis of the anterior adjacent margins at L5-S1. There was a loss of disc hydration and marked narrowing at the L5-S1 level. The documentation indicated the injured worker underwent x-ray studies. However, there was a lack of documentation indicating the injured worker had radiologic findings of instability upon flexion and extension x-rays. There was documentation indicating the injured worker had difficulty with flexion and extension upon physical examination. There was a lack of documentation of exceptional factors to support the necessity for a fusion without other surgical intervention. Given the above, the request for transforaminal lumbar interbody fusion at L5-S1 is not medically necessary.

Surgical Assistant: Upheld

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

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.

Lumbar Brace 4: Upheld

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

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.

Inpatient Hospital Stay For 2 Days: Upheld

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

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 Physical Therapy 3x6: Upheld

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

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.

Island Bandage X1 Box: Upheld

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

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.