

Case Number:	CM13-0039291		
Date Assigned:	12/18/2013	Date of Injury:	08/04/2010
Decision Date:	06/08/2015	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	10/04/2013

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: Minnesota, Florida
 Certification(s)/Specialty: Orthopedic 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 45-year-old male who sustained an industrial injury on 08/04/2010. Diagnoses include L4-L5 herniated nucleus pulposus with annular tear confirmed by discogram. Treatment to date has included diagnostic studies, medications, psychiatric evaluation, internal medicine consultation, and home exercise program. A physician progress note dated 08/16/2013 documents the injured worker continues to have ongoing low back pain with radiating symptoms to his bilateral lower extremities. His condition is worsening. Pain is affecting his activities of daily living. On examination, his lumbar spine reveals limited range of motion. There is distress on palpation. There is guarding noted. Straight leg raise maneuver is positive bilaterally. There is decreased sensation and weakness noted. A Magnetic Resonance Imaging of the lumbar spine done on 03/28/2011 revealed right neuroforaminally-extending L4-5 disc herniation, dorsally displacing and distorting the exiting right L4 nerve. Treatment requested is for inpatient stay for 2 days, and L4-L5 posterior lumbar interbody fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 Posterior Lumbar Interbody Fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Fusion (spinal).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 306, 307, 310.

Decision rationale: The most recent documentation from August 16, 2013 indicated ongoing low back pain with radiation to both lower extremities. Physical examination revealed limited range of motion of the lumbar spine. There was tenderness to palpation and guarding noted. Straight leg raising was positive bilaterally. There was decreased sensation although the dermatomal distribution is not documented. Weakness was also reported but the muscle groups have not been documented. The MRI scan of the lumbar spine dated March 26, 2011 is reviewed. The conclusions included 1. A 6 mm right neural foramen extending L4-5 disc protrusion/contained disc herniation, distorting the exiting right L4 nerve correlate clinically for its irritation. 2. A 3 mm central wide-based L5-S1 disc bulge. 3. L5-S1 greater than L1-2 and L4-5 disc desiccation without disc space narrowing. 4. A lower right lumbar rotatory scoliosis with psoas muscle asymmetry. 5. Multilevel L4-5 greater than L2-3 and L3-4 facet joint fluid suggesting facet synovitis. 6. A suspect 1.5 cm calcified gallstone needing ultrasound clearance to differentiate a bowel loop. Because of the surgical request in August 2013, a follow-up MRI study was authorized. However, the documentation does not include the MRI report from 2013. California MTUS guidelines indicate surgical considerations for severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise, activity limitation due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, 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 failure of conservative treatment to resolve disabling radicular symptoms. In this case, the MRI from 2011 revealed a herniation at L4-5 extending into the right neural foramen. The documentation indicates bilateral lower extremity pain. The clinical examination does not corroborate with the MRI findings. The guidelines indicate patients with increased spinal instability after surgical decompression at the level of the 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 guidelines do not recommend fusion in the absence of fracture, dislocation, complications of tumor, or infection. As such, the request for a lumbar fusion is not supported and the medical necessity of the request has not been substantiated.

Inpatient Stay (2-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.

