

Case Number:	CM14-0193028		
Date Assigned:	11/26/2014	Date of Injury:	06/24/2008
Decision Date:	01/16/2015	UR Denial Date:	10/18/2014
Priority:	Standard	Application Received:	11/18/2014

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 Neurology, has a subspecialty in Clinical Neurophysiology and is licensed to practice in Virginia. 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:

According to the records made available for review, the patient is a 48-year-old male with a date of injury of 6/24/2008. The mechanism of injury occurred while he was connecting a tractor-trailer when the "kill switch" failed. The injured worker was struck in the right lower extremity by the metal tongue of the trailer and he was tossed about 10-15 feet away from the trailer. He subsequently developed low back pain as well as right lower extremity pain. There is an electromyogram in the medical record dated 10/9/2008 which showed electro diagnostic evidence of a bilateral L5-S1 lumbar radiculopathy. There was also a mild left peroneal motor demyelinating neuropathy documented in this study. There was a delay in the right Tibial H reflex suggestive of an S1 radiculopathy. In there is documentation of a right lower extremity sympathetic block performed on 4/2/2013 which temporarily improved his pain control in his right leg thereby confirming a diagnosis of complex regional pain syndrome affecting the right lower extremity. There is a clinical note dated 9/4/2014 in which the patient complained of moderate pain in the lumbar spine and right lower extremity. The pain intensity on this exam was 6- 7/10. There is a neurologic exam dated 9/4/2014 which documented tenderness to the lower lumbar musculature. There was no tenderness to the posterior superior iliac spine region. Muscle strength was 5 out of 5 throughout all muscle groups in the lower extremities. Walking on tiptoes and heels was performed without difficulty. Deep tendon reflexes were 2+ bilaterally at the patellar and ankle jerk. Straight leg raise testing was negative bilaterally in both the sitting and supine position. There is no documentation in the medical record of an MRI L-spine. There is no documentation of nerve root dysfunction on clinical exam testing noted in the medical record.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spine fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

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

Decision rationale: American College of Occupational and Environmental Medicine (ACOEM) guidelines states that a spinal fusion is not recommended except for cases of trauma related spinal fracture or dislocation. Fusion of the spine is usually not considered during the first 3 months of the patient's symptoms. There is no scientific evidence about the long-term effectiveness with any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with conservative treatment. There is no good evidence from controlled trials that the spinal fusion alone is effective for treating any type of acute low back problem in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in a spinal segment operated on. According to the guidelines, lumbar fusion in patients with other types of low back pain very seldom cures the patient. In the case detailed above, the injured worker complains of chronic low back pain. There is no documentation of an MRI of the L-spine detailed in the medical record. There is no documentation in the medical record that reflects a diagnosis of a spinal fracture dislocation or of spondylolisthesis. Therefore, according to the guidelines and a review of the evidence, the request for a lumbar spine fusion is not medically necessary.