

Case Number:	CM14-0201569		
Date Assigned:	12/11/2014	Date of Injury:	01/23/2012
Decision Date:	02/04/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	12/03/2014

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 California. 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 41-year-old female who reported injury on 01/23/2012. The mechanism of injury was not submitted for review. The injured worker has diagnosis of L4-5 herniated nucleus pulposus with annular tear, left L4-5 radiculopathy, narrowing at L5-S1, chronic pain and neurological progression. Past medical treatment consists of physical therapy, injections and medication therapy. Medications include Voltaren XR, tramadol and omeprazole. It was noted on that the injured worker had undergone MRI of the lumbar spine on 09/12/2014, which revealed disc desiccation at L4-5. There was mild loss of posterior intervertebral disc height. There was a 3 mm central posterior disc protrusion with bilateral paracentral extension indenting the thecal sac. There was a 5 mm long linear hyperintensity, consistent with an annular tear. On 09/12/2014, the injured worker complained of low back pain which she rated a 6/10. She stated that the pain radiated to the left lower extremity, with associated numbness and tingling. Physical examination revealed diffuse tenderness and spasm over the L4-5 with limitation of motion. There was positive sciatic notch tenderness on the left. Straight leg raise test, tension Bowstring's test were positive on the left side. Motor examination revealed weakness in the extensor hallucis longus and tibialis anterior on the left side as compared to the right side. Pulses were 2+ and symmetrical. There were signs of some degree of hyperreflexia and positive Hoffman's sign. The treatment plan is for the injured worker to undergo anteroposterior lumbar fusion at L4-5 level. The provider feels that at this time the injured worker has failed conservative treatment to include physical therapy and injections and would benefit from surgery. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior posterior lumbar fusion at the levels of L4-L5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Low Back Disorders, Spinal Fusion

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

Decision rationale: The request for anterior posterior lumbar fusion at levels of L4-5 is not medically necessary. The California MTUS/ACOEM Guidelines do not recommend spinal fusion except in cases of trauma related spinal fracture or dislocation. Fusion of the spine is not usually considered during the first 3 months of symptoms. Surgical guideline considerations consist of severe and disabling lower leg symptoms and distribution consistent with abnormalities on imaging studies, activity limitations due to radiating leg pain for more than 1 month, clear clinical imaging and electrophysiologic evidence of a lesion that has been shown to benefit from both short term and long term surgical repair, failure of conservative treatment, and indication of psychological screening. The documentation indicated that the injured worker complained of constant low back pain with associated numbness and tingling which was aggravated by activities. Examination of the lumbar spine revealed tenderness and spasm, with positive sciatic notch tenderness on the left. It was noted on that the injured worker had undergone MRI of the lumbar spine on 09/12/2014, which revealed disc desiccation, mild loss of posterior intervertebral disc height, a 3 mm central posterior disc protrusion and 5 mm long linear hyperintensity, consistent with an annular tear. However, the MRI of the lumbar spine was not submitted for review, nor was there any evidence as to what type of conservative treatment care the patient had trialed and failed. Furthermore, the guidelines do not recommend spinal fusion unless there is evidence of spinal fracture or dislocation. There was no evidence or diagnosis submitted for review congruent with the above. Given the above, the injured worker is not within the guideline criteria. As such, the request is not medically necessary.

(Associated services) Assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 19th Edition, Surgical Assistant

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.

(Associated services) 2 Nights inpatient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hospital length of stay (LOS)

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.

(Associated services) Transportation service: 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.