

Case Number:	CM14-0214604		
Date Assigned:	01/07/2015	Date of Injury:	01/17/2006
Decision Date:	03/11/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/22/2014

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. 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: New York

Certification(s)/Specialty: Neurological 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:

This 36 year old female material handler wrenched her back while pushing a wheeled cart on 01/17/2006. Documentation shows she had received 12 sessions of physical therapy by 07/7/2014. The note from the therapist indicated she had had a 50% improvement with decreased pain on her activities of daily living. She noted continued difficulty with prolonged standing or walking and bending over to lift objects. Laseque's straight raising tests were negative, she had no weakness, and ankle and patellar reflexes were intact. MRI scan of 01/11/11 showed a Grade spondylolisthesis with anterolisthesis of L5 and a central disc protrusion at L4-5. Her PR2 note of 11/6/14 indicated she had had an increase in lower back pain radiating into her left leg. Examination disclosed moderate tenderness in her lumbar paraspinal area and sensation was decreased in the L5 distribution. Diagnoses were: Displacement of lumbar intervertebral disc without myelopathy, lumbago, thoracic or lumbosacral neuritis or radiculitis unspecified and degeneration of lumbar or lumbosacral intervertebral disc, spondylolisthesis, congenital-acquired spondylolisthesis-sciatica-spondylolysis, congenital, lumbosacral region. Utilization review denied the request for posterior lumbar decompression with fusion and instrumentation at the L4-S1 level, preoperative EKG, chest-ray and 3 hospital days. Documentation did not include evidence of lumbar instability or progression of her anterolisthesis, objective radiculopathy, worsening of neurological exam, active participation in a home exercise program or psychological assessment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior lumbar decompression with fusion at L4-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): 305-307.

Decision rationale: California MTUS chapter on low back pain (p.305) indicates severe disabling lower leg symptoms with objective signs of neural compromise and clear clinical evidence of a lesion which had been shown to benefit from surgical repair would warrant surgical consideration. Documentation does not provide this evidence. Psychological screening is recommended (p306) and evidently has not been obtained. No objective evidence of lumbar instability which would meet guidelines (p.307) is furnished. The denials of utilization review are upheld.

Associated surgical service: Pre-op chest x-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested operation is not necessary the requested associated service is not needed

Decision rationale: Since requested operation is not necessary the requested associated service is not needed.

Associated surgical service: Pre-op electrocardiogram: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested operation is not necessary the requested associated service is not needed

Decision rationale: Since requested operation is not necessary the requested associated service is not needed.

Associated surgical service: Inpatient hospital stay x 3 days: 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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested operation is not necessary the requested associated service is not needed

Decision rationale: Since requested operation is not necessary the requested associated service is not needed.