

Case Number:	CM14-0219105		
Date Assigned:	01/09/2015	Date of Injury:	05/23/2000
Decision Date:	03/13/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	12/31/2014

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: 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 46 year old female, who sustained an industrial injury on May 23, 2000. The injured worker has reported a back injury while moving a bucket of medical records. The diagnoses have included cervical musculoligamentous injury, lumbar musculoligamentous injury, bilateral lower extremity radiculopathy, L5-S1 herniated disc, severe lumbar degenerative disc disease, lumbar herniated nucleus pulposus, bilateral elbows lateral epicondylitis, cubital tunnel syndrome, bilateral upper extremity radiculopathy, and migraine headaches. Treatment to date has included oral and injected medications, and chiropractic care. Currently, the injured worker complains of constant lower back pain. The Primary Treating Physician's visit dated October 20, 2014, noted the injured worker in stable condition following a previous C4-C5 anterior cervical decompression procedure. Examination of the thoracolumbar spine revealed tenderness to palpation across the lumbosacral region. The Physician noted a prior request for authorization of a L5-S1 decompression and fusion, awaiting authorization for surgery. On December 19, 2014 Utilization Review non-certified a L5-S1 decompression and fusion, noting the request was not consistent with MTUS guidelines as that there was no current clinical evidence of lumbar radiculopathy that would benefit from decompression and no imaging evidence of instability, spondylolisthesis, or fracture that would require stabilization by L5-S1 fusion. The MTUS, ACOEM, Low Back Complaints Guidelines was cited. On December 31, 2014, the injured worker submitted an application for IMR for review of L5-S1 decompression and fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 Decompression and fusion: 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): 303, 305, 306, 307, 310.

Decision rationale: Per progress notes of 10/20/2014 she was in stable condition following a previous C4-5 anterior cervical decompression procedure. She was being treated for ongoing low back pain. A recommendation was made for L5-S1 decompression and fusion. On examination she was short statured, awake, alert and oriented. Cranial nerves were intact and symmetrical. She had full range of motion in the cervical spine. Examination of the thoracolumbar spine revealed tenderness to palpation across the lumbosacral region. Thoracolumbar flexion was 30 and extension 10, lateral bending was 20 bilaterally and rotation was 20. There was 5/5 muscle strength in the iliopsoas, quadriceps, hamstrings, tibialis anterior, extensor hallucis longus, and gastrocnemius muscles bilaterally. Deep tendon reflexes were 2+ at the knees and at the gastrocnemius tendons. Gait was normal. Lumbar MRI dated 5/31/2013 revealed evidence of L4-5 facet arthropathy of mild degree and ligamentum flammable hypertrophy causing mild left lateral recess stenosis. At L5-S1 there was a disc protrusion causing moderate right and mild left foraminal encroachment with potential for impingement on the L5 or S1 nerve roots. The request is for decompression and fusion at L5-S1. The information provided does not indicate any clinical evidence of radiculopathy such as loss of the Achilles reflex or sensory or motor deficit. The guidelines indicate that unequivocal objective findings that identify specific nerve root compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery as an option. If there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs or neural compromise, a surgical consultation is indicated. Also if there is evidence of activity limitations due to radiating leg pain and progression of lower leg symptoms or 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, then surgery is indicated. However, the documentation provided does not indicate objective neurologic findings on examination to support the request for surgical decompression. The request for a spinal fusion at L5-S1 per guidelines should be supported by evidence of degenerative spondylolisthesis and associated instability after surgical decompression at that level. The guidelines do not recommend spinal fusion in the absence of fracture, dislocation, complications of tumor, or infection per table 128, page 310. As such, the request for surgical decompression and spinal fusion at L5-S1 is not supported by guidelines and the medical necessity of the request is not substantiated.