

Case Number:	CM14-0035260		
Date Assigned:	06/23/2014	Date of Injury:	12/29/1998
Decision Date:	01/23/2015	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/21/2014

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, has a subspecialty in Spine Surgery and is licensed to practice in New Jersey. 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 58-year-old male who reported an injury on 12/29/1998. The mechanism of injury was not submitted for clinical review. The diagnoses include low back pain, lumbar spinal stenosis and right lumbar radiculopathy. Previous treatments include medication and epidural steroid injections. Diagnostic testing includes an MRI of the lumbar spine dated 03/27/2013, which revealed a far lateral right L5-S1 osteophyte disc combination impinging on the right L5 nerve root; neural foraminal encroachment at L5-S1. On 02/24/2014, it was reported the injured worker reported no relief with the previous epidural steroid injection. He complained of low back pain and right leg pain. He rated his pain 4/10 to 5/10 in severity. On the physical examination the provider reported the injured worker to have normal sensation to light touch in all 4 extremities. There was no tenderness to palpation of the low back. There was limited lumbar range of motion of the lumbar spine. The provider noted axial back pain was present with radiation to the lateral aspect of the leg, the dorsum of the foot and the big toe on the right, which was consistent with L5 radiculopathy. There was axial present with radiation to the posterior aspect of the calf, lateral border of the left foot and the little toe on the right, which was consistent with S1 radiculopathy. The provider requested a right L5-S1 posterior lumbar interbody fusion due to a failure of conservative care and epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right (R) L5-S1 posterior lumbar interbody fusion (PLIF): 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 (<http://www.odg-twc/lowback.htm#Fusion>)

MAXIMUS 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).

Decision rationale: The California MTUS/ACOEM Guidelines state consideration for surgery in cases of severe disabling lower leg symptoms in a distribution consistent with abnormalities on imaging study, preferably with accompanying objective signs of neural compromise, activity limitation due to radiating leg, leg pain for more than 1 month or extreme prognosis of lower symptoms, clear clinical imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both short and long term from surgical repair, failure of conservative treatment to resolve the disabling radicular symptoms. In addition, the Official Disability Guidelines state criteria for lumbar spinal fusion for chronic low back problems, fusion should not be considered within the first 6 months of symptoms except where fracture, dislocation or progressive neurological loss. Indications include neural arc defect, spondylotic spondylolisthesis, cognitive neural arc hypoplasia, segmental instability, objective, demonstrable, excessive motion as in degenerative spondylolisthesis, surgical induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy; functional spinal unit failure, instability including 1 or 2 level segmental failures with progressive degenerative changes, loss of height, disc loading capability. The clinical documentation submitted, failed to indicate the injured worker had significant objectively found structural instability. There is lack of documentation of spinal fracture, disc location or spondylolisthesis or frank neurogenic compromise. Additionally, the length of time the patient had underwent conservative care was not submitted for clinical review. There is lack of documentation of an adequate trial of conservative therapy. Therefore, the request is not medically necessary.

Hospital inpatient stay x 1 day: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Hospital Length of Stay (LOS) http://www.odg-twc.com/odgtwx/low_bckhtm#Hospitallenghtofstay.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Hospital Length of Stay (LOS).

Decision rationale: As the primary service is not supported, this associated service is also not supported.

