

Case Number:	CM15-0176584		
Date Assigned:	09/28/2015	Date of Injury:	05/02/2011
Decision Date:	11/10/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/08/2015

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: California

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 52-year-old male who sustained an industrial injury on 5-2-11. A review of the medical records indicates he is undergoing treatment for grade I spondylolisthesis L4-L5 with hypermobility flexion 6.0 millimeters, extension 0 millimeters, right foraminal disc protrusion L4-L5, resulting in foraminal stenosis, and moderate central canal stenosis L4-L5. He is also undergoing treatment for derangement of the ankle and foot and internal derangement of the knee. Medical records (8-12-15) indicate complaints of lower lumbar back pain with radiation to the lower extremities, affecting the left greater than the right lower extremity. The pain "primarily" extends into the left buttock, posterior thigh, calf, and into the foot. The progress report indicates that the injured worker's "activities are restricted due to his pain complaints". The physical exam reveals decreased Achilles reflex on the right and absent reflex on the left. The treating provider indicates "palpation of the lumbar spine reveals no focal areas of tenderness". Diagnostic studies have included x-rays of the lumbar spine and an MRI of the lumbar spine. Treatment has included physical therapy, chiropractic therapy, and acupuncture. He is also receiving the following medications: Omeprazole 20mg daily, Cidaflex, 1 tablet three times daily, Norco 10-325, 2 tablets every morning and every evening, Voltaren 1% gel twice daily, and Ketoprofen ER 200mg daily. He is currently (8-6-15) not working due to the unavailability of modified duties. The treatment recommendation is for surgical intervention. The utilization review (8-25-15) indicates the requested treatment as transforaminal lumbar interbody fusion L4-L5 right posterior instrumented fusion L4-L5 right, assistant surgeon, preoperative medical clearance, and postoperative lumbar brace. The requests were deemed not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Lumbar Interbody Fusion L4-5 Right Posterior Instrumented Fusion L4-5 Right: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar and Thoracic (Acute & Chronic), Lumbar Spinal Fusion.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, spinal fusion.

Decision rationale: The ACOEM Guidelines state that lumbar fusion, except for cases of trauma-related spinal fracture or dislocation, is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. According to the ODG, fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient, there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm, severe stenosis or psychiatric clearance from the exam note of 8/16/15 to warrant fusion. Therefore, the request is not medically necessary.

Assistant surgeon: 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.

Pre-Operative Medical Clearance: 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.

Post-Operative Lumbar Brace: 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.