

Case Number:	CM13-0055174		
Date Assigned:	12/30/2013	Date of Injury:	10/19/1998
Decision Date:	03/24/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	11/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Fellowship trained in Spine Surgery and is licensed to practice in Texas and 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 physician 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 patient is a 60 year old female who reported injury on 10/19/1998. The mechanism of injury was not provided. The patient had a limited 3-view lumbar spine x-ray exam on 08/26/2013, which revealed L3-5 degenerative disc disease evidenced by a moderate loss of disc height space, and L5-S1 degenerative disc disease evidenced by severe loss of disc height space, and sacralization of L5 was present on the left. The patient had a lumbar myelogram on 08/26/2013, which revealed sacralization of the L5 on the left, with a moderate loss of disc space height at L3-4 and L4-5. The vertebral body heights were preserved, and there was no evidence of spondylolisthesis. The patient had an MRI of the pelvis without contrast on 01/04/2013, which did not address the lumbar spine. The patient had a CT scan of the lumbar spine post-myelogram on 08/26/2013, and was noted to be compared with the MRI of the lumbar spine on 07/24/2012. There was noted to be partial sacralization of L5 on the left, such that the left L5 transverse process was hypertrophied and was partially fused with a pseudoarthrosis at the superior margin of S1. The vertebral body heights were preserved. There was accentuated lordosis of the lumbar spine, and no evidence of spondylolisthesis or spondylosis. At the level of L3-4, there was a moderate loss of disc herniation space with minimal anterior spondylosis and a 2 mm posterior broad-based disc bulge that effaced and flattened the ventral thecal sac. Ligamentum flavum hypertrophy effaced the dorsal lateral margins of the thecal sac. There was moderate stenosis of the thecal sac. There was moderate left foraminal stenosis and an abutment of the left foraminal L3 nerve. There was lateral recess nerve root sleeve effacement and abutment of the butting bilateral L4 nerve roots present. At L4-5, the disc height space was moderately narrowed, with a 2 mm broad-based disc bulge present, which minimally effaced the ventral margin of the thecal sac. Moderate bilateral facet arthropathy was present with subchondral microcyst formation.

The patient had moderate right neural foraminal stenosis present with abutment of the inferior margin of the right foraminal L4 nerve. There was moderate to severe left neural foraminal stenosis and a lack of opacification of the left foraminal L4 nerve root sleeve, likely attributed to encroachment. There was lateral recess nerve root sleeve effacement and abutment of the butting bilateral L5 nerve roots. At L5-S1, there was no evidence of significant posterior disc bulge protrusion or extrusion, and there was sacralization of the L5 on the left. There was no effacement of the thecal sac. However, there was a 4 mm hypertrophic osteophyte arising from the right L5 inferior endplate uncinat process, and protrusion into the neural foramen. There was mild right neural foraminal narrowing. There was mild right facet arthropathy. There was left foraminal 5 mm hypertrophic osteophyte formation protruding into the left neural foramen, causing mild narrowing. There was left lateral margin of the disc space, demonstrating a 3 mm transverse syndesmophyte. The syndesmophyte and sacralization of the L5 on the left created moderately stenotic osseous canal surrounding and abutting the exiting left lateral L5 nerve. The patient had a nerve conduction study on 05/15/2013, which revealed the electrodiagnostic testing was normal, with no evidence of peripheral nerve entrapment or radiculopathy. The most recent clinical office note indicated the patient had a chief complaint of right leg, left leg, and back pain. The description of the lower extremity pain revealed it was burning, punishing, incapacitating, sharp, and shooting. The patient had complaints of bilateral lower extremity weakness. The patient's prior treatments were noted to include acupuncture, massage, Pilates, chiropractic care, a lumbar brace, a pain diary, gym attendance, lumbar facet blocks, lumbar epidural injections, and self-directed therapy. The patient's diagnoses were noted to include lumbar central spinal stenosis and lumbar spondylolisthesis. The treatment recommendation was for a lumbar spine surgery at L3-5; lateral interbody fusion and posterior decompression at L3-5. The request additionally was made for an assistant surgeon and preoperative medical clearance consult.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Decompression and Fusion with instrumentation with Assistant Surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation 2011 Surgeons as assistants at surgery

Decision rationale: ACOEM Guidelines indicate a surgical consultation is appropriate for patients with severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than 1 month, or extreme progression of lower leg symptoms, clear clinical, imaging, and electro physiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, they recommend a fusion for patients with increased spinal stability not work-

related after a surgical decompression at the level of degenerative spondylolisthesis. They do not specifically; however, address a decompression. As such, secondary guidelines were sought. Official Disability Guidelines indicate there should be myotomal and dermatomal deficits for the corresponding levels to support patient complaints of radiculopathy. EMGs are noted to be optional to obtain unequivocal evidence of radiculopathy, but are not necessary if radiculopathy is already clinically obvious. There should be imaging studies, concordance between radicular findings on radiologic evaluation and physical examination findings to include nerve root compression, lateral disc rupture, or lateral recess stenosis, and there should be documentation of conservative treatments, including all of the following activity modifications, drug therapy and supportive provider referral. Clinical documentation submitted for review indicated the patient had trialed muscle relaxants, an epidural steroid injection, and physical therapy, as well as activity modification. The patient's imaging studies indicated abutment, but not specific nerve root compression at the levels of the requested surgery. There was a lack of objective physical findings to support the patient's complaints including myotomal and dermatomal findings. ACOEM guidelines indicate fusions are appropriate for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. The requested decompression was not supported and, as such, the requested fusion would not be supported. Additionally, the request as submitted failed to indicate the level for the surgery, as well as the laterality. Per 2011 Surgeons as Assistants at Surgery, a surgeon would be appropriate for the levels of surgery. However, as the surgery was not medically necessary, the assistant would not be medically necessary. Given the above, the request for Lumbar Decompression and Fusion with instrumentation with Assistant Surgeon is not medically necessary.

Pre-op medical clearance consult: 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
<http://www.choosingwisely.org/?s=preoperative+surgical+clearance&submit>

Decision rationale: As the surgical procedure was not medically necessary, the request for a preoperative medical consult is not medically necessary.