MAXIMUS Federal Services

Case Number:	CM14-0004726		
Date Assigned:	01/22/2014	Date of Injury:	03/16/1988
Decision Date:	07/03/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/10/2014

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 Fellowship trained in Spine Surgery and is licensed to practice in 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 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 70-year-old male with an injury date of 03/16/1988. The mechanism of injury was not provided. The injured worker's diagnoses include lumbar stenosis, spondylolisthesis, radiculopathy, and back pain. An official MRI of the lumbar spine dated 03/05/2013 signed by [redacted] was noted to reveal moderate L2-3 and L3-4 central canal stenosis, grade I spondylolisthesis of L4-5, L4-5 significant bilateral facet arthrosis, with right L4-5 mild central canal stenosis and bilateral moderate frontal narrowing, L5-S1 significant disc space narrowing, and bilateral L5-S1 moderate foraminal narrowing. The clinical note dated 11/15/2013 noted that the injured worker had a prior lumbar surgery at L4-5 in 1991 and that the injured worker had symptom relief for approximately two (2) years and was no having return of symptoms to include back pain and bilateral lower extremity numbness and weakness. The clinical note also indicated that the patient had received many injections in the past which had not been effective, as well as many courses of physical therapy. Upon examination, the injured worker was noted to have decreased lumbar spine range of motion with pain, decreased sensation in the L5 and S1 distribution on the right, absent ankle jerks bilaterally, and was noted to be hyperreflexic. The clinical note dated 12/03/2013 noted that the injured worker had back pain that radiated into the bilateral lower extremities and that the pain was rated 8-9/10. The physical examination noted motor strength of 5/5 and decreased sensation in the right foot in the L5 distribution. The clinical note dated 12/11/2013 noted that the injured worker continued to complain of lumbosacral spine pain that was rated 2/10 to 4/10. It was also noted that the injured worker had complaints of numbness and significant reoccurring weakness in the bilateral lower extremities. Physical exam findings included tenderness to the bilateral paraspinal musculature, decreased sensation to pinwheel examination in the right lateral foot, left thigh and medial foot, and global weakness in the bilateral lower extremities. The deep tendon reflexes were equal and

decreased bilaterally. A review of records indicated that electromyography performed on 11/11/2013 had revealed evidence of L5 and S1 radiculopathy. The clinical note dated 12/20/2013 referenced an unofficial MRI that was noted to reveal that the injured worker had significant stenosis of C5 and C6, as well as spondylolisthesis at C7 through T1, and that there was severe disc bulging. It was noted that the cervical spine findings would mimic the injured workers current lumbar spine findings. However, it was noted that, due to the injured worker's balance difficulties and myelopathic findings, the treating physician felt that the cervical spine needed to be addressed before the lumbar spine as placing him under anesthesia would place him at risk for central cord syndrome. The request for authorization for a L4-S1 transforaminal lumbar interbody fusion was submitted on 12/26/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) TRANSFORAMINAL INTERBODY FUSION AT L4-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305 and 307. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The MTUS/ACOEM Guidelines indicate that surgical consideration for low back complaints is indicated for injured workers who have severe disabling lower leg symptoms consistent with abnormalities on imaging studies, activity limitations due to radiating leg pain for more than one (1) month, clear clinical, imaging, and electrophysiological evidence, and failure of conservative treatment to resolve disabling radicular symptoms for three (3) months. In addition, the guidelines state evidence of increased spinal instability (not work related) after surgical decompression at the level of degenerative spondylolisthesis may support fusion. The documentation submitted for review included evidence of spondylolisthesis on MRI, as well as severe disabling lower leg symptomatology and significant neurological deficits which correlate with imaging and electrodiagnostic testing. Additionally, it was shown that the injured worker had failed appropriate conservative care treatments. Based on the above, a lumbar fusion procedure would be supported by the referenced guidelines; however, as the documentaion specifically stated that, based on findings, the treating physician felt that the cervical spine needed to be addressed before the lumbar spine as placing him under anesthesia would place him at risk for central cord syndrome. Due to the lack of further documentation stating these concerns had been addressed, the request for a transforaminal interbody fusion at L4-S1 is not supported. As such this request is not medically necessary.