

Case Number:	CM14-0104530		
Date Assigned:	07/30/2014	Date of Injury:	09/20/2012
Decision Date:	08/29/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/07/2014

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 Orthopaedic 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:

This 39-year-old male cable field technician sustained an industrial injury on 9/20/12. The mechanism of injury was not documented. The patient underwent right-sided microscopic L5 and S1 partial laminectomy and discectomy on 8/22/13. The 3/18/14 lumbar spine 5-view x-ray series showed moderate disc space narrowing at L5/S1 with small endplate osteophyte and sclerosis. There was no spondylosis or spondylolisthesis on oblique view. The 4/2/14 lumbar MRI impression documented normal alignment and vertebral bodies of normal height. There was disc desiccation at L5/S1 with broad midline and right paracentral disc protrusion measuring 6 mm resulting in abutment of the bilateral descending S1 nerve roots and mild central canal stenosis. The 6/4/14 treating physician report cited persistent back pain radiating to the right lower extremity since the discectomy performed 8/22/13. He participated in post-operative non-surgical treatment including rest, therapy and medication with no improvement. Physical exam documented flexion 35 degrees, extension 20 degrees, positive right straight leg raise, mildly positive cross straight leg raise on the left, 4+/5 right extensor hallucis longus strength, right L5 and S1 sensory deficit, reflexes 0 to 1+ and symmetrical, and no pathological reflexes. The diagnosis was recurrent right sided L5/S1 disc herniation with instability. The treating physician stated the MRI showed recurrent disc herniation narrowing the right lateral recess and neural foramina. There was retrolisthesis at L5/S1 with severe disc desiccation and settling. Surgical treatment was indicated including bilateral L5/S1 revision decompression with fusion, given the instability which is present. The 6/27/14 utilization review denied the request for lumbar surgery as there was no documentation of conservative treatment for the recent recurrence of symptoms and no evidence of a recent pre-surgical psychology evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Preoperative Medical Clearance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Low Back Lumbar & Thoracic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Institute for Clinical Systems Improvement (ICSI), Preoperative evaluation.

Decision rationale: As the request for lumbar surgery is not medically necessary, the associated request for pre-operative medical clearance is also not medically necessary.

18 Post Operative Physical Therapy Sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: As the request for lumbar surgery is not medically necessary, the associated request for 18 post-operative physical therapy sessions is not medically necessary.

Posterolateral Fusion using Rigid Segmental Internal Fixation and Anterior Lumbar Inter body Fusion at L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Fusion (spinal).

Decision rationale: The ACOEM Revised Low Back Disorder guidelines recommend lumbar discectomy for patients with radiculopathy due to on-going nerve root compression who continue to have significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. Lumbar fusion is not recommended as a treatment for patients with radiculopathy from disc herniation. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Pre-operative clinical surgical indications require completion of all physical

therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. There is no imaging documentation of spinal segmental instability. The patient has been treated for depression with no recent psychosocial evaluation evidence of/for surgical clearance. Therefore, this request for posterolateral fusion using rigid segmental internal fixation and anterior lumbar interbody fusion at L5/S1 is not medically necessary.