MAXIMUS Federal Services

Case Number:	CM14-0105874		
Date Assigned:	08/01/2014	Date of Injury:	06/13/2011
Decision Date:	10/09/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	07/09/2014

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 and is licensed to practice in Texas. 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 41-year-old male who reported an injury on 06/13/2011. The mechanism of injury was the injured worker was reaching up to pull and push trailer doors and felt a "tweak" in his low back. The injured worker's diagnoses included retrolisthesis on L3-4 and L4-5, left greater than right, and left greater than right lower extremity radiculopathy. The examination of 05/14/2014 revealed the injured worker had complaints of low back pain. The injured worker was noted to have undergone a course of physical therapy and Platelet Rich Plasma injections. The injured worker injured his right knee and underwent surgery for a torn meniscus. The present complaints included the injured worker had complaints of low back pain, worse when sitting, standing, and walking. The pain radiated down the back of the leg. There was numbness in the right anterior thigh. There was occasional numbness in the left posterior thigh. The injured worker's medications were noted to include Norco. The injured worker was noted to be a nonsmoker. The physical examination revealed the injured worker's gait was normal, and the injured worker was able to walk on his toes and heels without observed deficits. The injured worker had moderately diminished flexion, extension, and bilateral flexion with back pain. The motor strength was within normal limits. The injured worker had decreased light touch sensation in the right anterior thigh. The injured worker had lumbosacral tenderness in the mid line. The documentation indicated the injured worker had 7 views of the lumbar spine on 05/14/2014 with an asymmetric disc collapse at L3-4. There was a large right lateral osteophyte at L3-4 and a mild loss of disc height at L4-5 and L5-S1. There was 13 degrees of kyphotic angulation at L3 of L4 on flexion. This corrected to 0 degrees on extension. There was 5 mm of retrolisthesis of L3 with respect to L4 on flexion that decreased to 3 degrees on extension. There was no evidence of spondylosis. The injured worker was noted to have undergone an MRI of the lumbar spine on 09/09/2011 which revealed desiccation and advanced loss of disc height at L3-4. There

was a 1 mm to 2 mm of retrolisthesis of L3 with respect to L4. There was early degenerative change of L3-4 and L4-5 discs with desiccation and mild loss of disc height. There was a cyst in the canal just caudal to the L4-5 disc and the significant of which was not readily apparent, although it could represent fluid due to a small disc protrusion just adjacent to the cyst. The injured worker underwent an MRI of the lumbar spine on 09/26/2012 which revealed retrolisthesis and disc space narrowing at L3-4 that had progressed. There was 5 mm of retrolisthesis with increased narrowing of the disc space. There remained desiccation and mild loss of disc height at L4-5 level without central foraminal stenosis. There was a 3 mm central disc protrusion at L5-S1 level without central foraminal stenosis. The injured worker was noted to undergo a subsequent MRI of the lumbar spine on 10/02/2012 which revealed left lateral scoliosis of the lumbar spine. There was early disc desiccation at L3-4, L4-5, and L5-S1. There was reduced intervertebral disc height at L3-4 levels. At L3-4, there was diffuse disc protrusion compressing the thecal sac. There was bilateral neural foraminal stenosis encroaching the left and right L3 exiting nerve roots, more so on the right. The disc measurements was neutral of 3.0 mm. At L4-5, the focal central disc protrusion was superimposed on the diffuse disc bulge indenting the thecal sac. There was bilateral neural foraminal stenosis encroaching the left and right L4 exiting nerve roots. The disc measurement in neutral was 3.8 mm. At the level of L5-S1, there was diffuse disc protrusion with annular tear without effacement of the thecal sac. There was neural foraminal narrowing without significant impingement of the exiting nerve roots. The disc measurement was neutral 4.0 mm. There was grade 1 retrolisthesis of L3/4 and L4/5. The treatment plan included the injured worker needed an interbody fusion of L3-4, L4-5, and L5-S1 utilizing lateral approach at L3-4 and L4-5 and a posterior approach at L5-S1. Additionally, it was documented the injured worker would need interbody fusion cages at L3-4 and L4-5 with a posterior lumbar interbody fusion at L5-S1 and a laminectomy at L3-S1 with posterior spinal fusion with instrumentation at L3-S1. The diagnoses included unstable retrolisthesis, advanced degenerative disc disease at L3-4 and degenerative discs at L4-5 and L5-S1. There was no Request for Authorization submitted for review for the requested procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lateral interbody fusion with interbody fusion cages L3-L4 and L4-L5, posterior lumbar interbody fusion with interbody fusion L5-S1 and laminectomy L3-S1 with posterior spinal fusion with instrumentation L3-S1 with iliac crest bone graft: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Pages 305-308.

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

Decision rationale: The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic

evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on.

Clinicians should consider referral for psychological screening to improve surgical outcomes. There would be no necessity for electrodiagnostic studies for the requested intervention. The clinical documentation submitted for review indicated the injured worker had objective findings upon MRI at L3-4 and L4-5. The injured worker had radiographic evidence of instability including 13 degrees of kyphotic angulation at L3-4 that corrected to 0 degrees on extension. The injured worker had 5 mm of retrolisthesis of L3 on L4 on flexion which was decreased to 3 degrees of extension. There was a lack of documentation indicating involvement of the L5-S1 and a necessity for L5-S1 intervention. Additionally, there was a lack of documentation indicating the injured worker had a psychological screening regarding a 3 level fusion. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for Lateral interbody fusion with interbody fusion cages L3-L4 and L4-L5, posterior lumbar interbody fusion with interbody fusion L5-S1 and laminectomy L3-S1 with posterior spinal fusion with instrumentation L3-S1 with iliac crest bone graft is not medically necessary.