

Case Number:	CM14-0131718		
Date Assigned:	08/20/2014	Date of Injury:	11/27/2009
Decision Date:	10/08/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/18/2014

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 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 53-year-old female who reported an injury on 11/27/2009. The injury reported occurred when she was getting out of her truck and hit her head against a frame. Following the injury, it was noted that she had neck pain radiating to the left arm and left sided back pain. She is diagnosed with spondylolisthesis at L4-5 and lumbar radiculopathy. Her past treatments were noted to have included a cervical decompression and fusion at C5-6 and C6-7, as well as physical therapy, chiropractic treatment, acupuncture, medications, and epidural steroid injections. Her diagnostic studies included x-rays of the lumbar spine with flexion and extension views on 04/08/2014, which were noted to reveal worsening spondylolisthesis at L5-S1. It was specified that she had mostly mild spondylolisthesis showing up at the L4-5 level with significant progression of instability at the L5-S1 level when compared to a previous x-ray in 2011. An MRI of the lumbar spine was performed on 05/29/2014 and revealed a 2 mm disc bulge toward the inferior recesses of the bilateral neural foramina, which are mildly narrowed at the L4-5 level, as well as mild bilateral facet arthropathy and abutment and minimal effacement of the ventral margin of the thecal sac, with ligamentum flavum hypertrophy and mild central canal stenosis. At the L5-S1 level, the MRI revealed a 3 mm spondylolisthesis resulting in dorsal uncovering of the disc, as well as moderate bilateral facet arthropathy, moderate bilateral neural foraminal stenosis, and abutment of the right and encroachment on the left foraminal L5 nerves. It was also noted there was a 4 mm synovial cyst arising from the dorsal margin of the left facet joint. On 07/01/2014, the injured worker presented for followup and was noted to have persistent symptoms of severe pain in the lower back with radiating pain down both legs, worse on the right. Her physical examination revealed a positive straight leg raise on the right and decreased sensation in the right L4 distribution. Her medications were not specified within the clinical note. The treatment plan included recommendation for laminectomy posterior spinal

fusion with instrumentation post lateral interbody fusion at L4-5, L5-S1. It was noted that surgery was recommended due to her symptomatic spondylolisthesis and failure of conservative treatment. The Request for Authorization form was not submitted in the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Laminectomy posterior spinal fusion with instrumentation post lateral interbody fusion at L4-L5, L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Fusion (spinal).

Decision rationale: According to the California MTUS/ACOEM Guidelines, spinal surgery may only be considered when serious spinal pathology and/or nerve root dysfunction has been unresponsive to at least 3 months of conservative therapy and is obviously due to a herniated disc. Documentation should show: severe and disabling radiating symptoms in a distribution consistent with abnormalities on imaging studies, as well as accompanying objective signs of neural compromise; activity limitations due to radiating extremity pain that have been present for more than 1 month, or an extreme progression of radiating symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit from surgical repair; and the failure of at least 3 months of conservative treatment to resolve disabling radicular symptoms. Additionally, the guidelines state that spinal fusion may be considered when there is clear evidence of instability. More specifically, the Official Disability Guidelines state that lumbar spinal fusion should not be considered within the first 6 months of symptoms except when there is evidence of fracture, dislocation, or progressive neurologic loss. The guidelines state that indications for spinal fusion may include: a neural arch defect with spondylolytic spondylolisthesis or congenital neural arch hypoplasia; objectively demonstrable segmental instability; primary mechanical back pain with failure of functional spinal unit and instability; when revision surgery is performed for failed previous operations if significant functional gains are anticipated; when there is infection, tumor, or deformity of the lumbosacral spine that causes intractable pain, neurological deficit, and functional disability; or after the failure of 2 discectomies on the same disc. Additionally, the guidelines state that prior to spinal fusion, all pain generators need to be identified and treated; all physical medicine and manual therapy intervention has been tried and failed; x-rays have demonstrated spinal instability, and MRI or other diagnostic testing has demonstrated disc pathology which has been correlated with symptoms and physical examination findings; the spinal pathology is limited to 2 levels; psychosocial screening has been performed and confounding issues have been addressed; and recommendations have been made for patients who smoke to refrain from smoking for at least 6 weeks prior to surgery and during the period of fusion healing. The injured worker was noted to have persistent low back pain with radiating symptoms into the bilateral lower extremities. Additionally, she was noted to have decreased sensation in a right L4 distribution and a positive

straight leg raise to the right. An MRI and x-rays revealed evidence of spondylolisthesis at L5-S1, and she was noted to have mildly narrowed bilateral neural foramina at L4-5 and moderately narrowed bilateral neural foramina and bilateral nerve involvement at L5-S1. In addition, the documentation indicated that she had failed treatment with medications, physical therapy, chiropractic treatment, and epidural steroid injections. However, the documentation did not indicate that length of time the injured worker had been treated with conservative therapy and the duration and severity of her radiating symptoms. The submitted documentation indicated that she had previously been treated with cervical pain with radicular symptoms, but there is no evidence beyond 02/05/2014 that she had severe low back pain with radiating symptoms and whether she had been treated with conservative care for her low back complaints prior to that date. The documentation also did not provide evidence that electrodiagnostic studies had been performed and revealed evidence of radiculopathy. Also, her physical examination did not indicate whether she had any motor strength or reflex deficits in a specific distribution to correlate with her MRI findings. She was only noted to have decreased sensation in an L4 distribution with no documentation showing physical examination findings of radiculopathy that correlate with the L5-S1 level. Additionally, the documentation did not support progressive neurological deficits. There was also no documentation indicating that all pain generators had been identified and treated, that she had had a psychosocial screening and confounding issues had been addressed, or that she had been advised to refrain from smoking if necessary. In the absence of this documentation with further history regarding the injured worker's low back and lower extremity symptoms and treatment, as well as electrodiagnostic studies and clear correlation of significant physical examination findings, symptoms, and diagnostic evidence, the request is not supported at this time. As such, the request for Laminectomy posterior spinal fusion with instrumentation post lateral interbody fusion at L4-L5, L5-S1 is not medically necessary.

Hospital inpatient stay, QTY: 5 days: 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: As the primary service is not supported, this associated service is also not supported.

Assistant surgeon, QTY: 1:

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: As the primary service is not supported, this associated service is also not supported.