MAXIMUS Federal Services

Case Number:	CM14-0170380		
Date Assigned:	10/20/2014	Date of Injury:	01/18/2013
Decision Date:	11/20/2014	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	10/15/2014

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 Spine 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 68-year-old female who reported an injury on 01/18/2013. While working as a CNA she was walking in the hallway, when her foot got stuck and she lost her balance, she was able to break her fall on the handrail, she twisted her right foot inward, started to feel pain in her right foot, and the next day had lower back pain. The injured worker complained of continued severe lower back pain that radiated to the leg. The diagnosis included a lumbar spinal stenosis at the L4-5 with spondylolisthesis at the L4-5. The diagnoses included an MRI of the lumbosacral spine dated 05/06/2014 that revealed mild relatively flattened L3-4 vertebral bodies, moderate levoscoliosis, arthritic changes at the facet joints at the L4-5 and L5-S1 with significant decreased height space at the L5-S1. Appearance suggests fusion/near fusion. The objective findings dated 08/30/2014 of the lumbar spine revealed tenderness to palpation of the paraspinous muscles with lumbar spasms. The range of motion included flexion at 60 degrees and extension at 25 degrees along with right side bending at 25 degrees and left sided bending at 25 degrees. The neurologic examination revealed deep tendon reflexes 2+ bilaterally at the knees and ankles. The injured worker had clonus on the right with a positive Homan's sign bilaterally. Sensory was decreased with light touch at the L5 dermatomes on the right. Past treatments included lumbar brace with a corset, TENS unit, acupuncture, chiropractic adjustments, and facet blocks. The treatment plan included a lumbar spinal fusion. The Request for Authorization dated 10/20/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Spine Fusion: Upheld

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

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

Decision rationale: The request for lumbar spine fusion is not medically necessary. The California MTUS/ACOEM Guidelines indicate that within the first 3 months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy (and obviously due to a herniated disc) is detected. Disc herniation, characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis, may impinge on a nerve root, causing irritation, back, and leg symptoms, and nerve root dysfunction. The presence of a herniated disc on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disc herniation's that apparently do not cause symptoms. Some studies show spontaneous disc resorption without surgery, while others suggest that pain may be due to irritation of the dorsal root ganglion by inflammogens (metalloproteinase, nitric oxide, interleukin 6, prostaglandin E2) released from a damaged disc in the absence of anatomical evidence of direct contact between neural elements and disc material. Therefore, referral for surgical consultation is indicated for patients who have: Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, and activity limitations due to radiating leg pain for more than 1 month or extreme progression of lower leg symptoms. 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. Failure of conservative treatment to resolve disabling radicular symptoms. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and, especially, expectations are very important. Patients with acute low back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may help resolve the symptoms. Except for cases of trauma related spinal fracture or dislocation, fusion of the spine is not usually considered during the first 3 months of symptoms. Patients with increased spinal instability (not work related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. 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 spondylosis compared with natural history, placebo, or conservative treatment. 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. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as "much better" in the surgical group versus 14% "much better" in the non-fusion group (a 15% greater chance of being "much better") versus a 17% complication rate (including 9% life threatening or reoperation). The documentation provided indicated that the injured worker has had a psychiatry evaluation and failed conservative care. The MRI indicated arthritic changes at the facet joints at the L4-5 and L5-S1 with significant decreased height in the disc space. However, the request did not indicate

the levels or the location for the spinal fusion. As such, the request is not medically necessary.