

Case Number:	CM14-0025159		
Date Assigned:	06/13/2014	Date of Injury:	02/01/2009
Decision Date:	07/30/2014	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	02/27/2014

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 65-year-old male laborer sustained an industrial injury on 2/1/09, relative to lifting. Records indicated that an L5/S1 decompression and fusion had been planned in 2012 but the patient was unable to obtain medical clearance due to his diabetes and hypertension. Surgery was again requested in July 2013. The 10/2/13 utilization review denial recommended updated imaging. The 12/16/13 lumbar MRI impression documented disc bulges at L1/2, L2/3 and L3/4 mildly impressing the the cal sac. At L4/5, there was a broad-based disc protrusion mildly impressing the the cal sac with bilateral facet arthrosis, ligamentous flavum hypertrophy, and moderate bilateral neuroforaminal stenosis. There was a grade 1 spondylolytic anterolisthesis of L5 with bilateral facet arthrosis and marked bilateral neuroforaminal narrowing. The 12/18/13 flexion/extension x-ray report impression documented decreased range of motion on flexion and extension which may reflect an element of myospasm. There was degenerative grade 1 spondylolisthesis of L5 over S1. There were degenerative marginal osteophytes off the anterior superior end plates of L1 and L4. The 1/22/14 CT scan conclusion documented L4/5 disc bulge resulting in moderate bilateral neuroforaminal narrowing and mild to moderate canal stenosis. There was grade 1 anterolisthesis at L5/S1. There was an L5/S1 disc bulge resulting in moderate to severe bilateral neuroforaminal narrowing, vacuum phenomenon, and moderate canal stenosis. The 1/10/14 treating physician report cited MRI findings of severe neuroforaminal stenosis at L5/S1 associated with an adult lytic spondylolisthesis and significant degenerative changes at L4/5 with bilateral neuroforaminal stenosis. Instability was reported on flexion/extension x-rays. The 2/10/14 utilization review denied the request for multilevel lumbar laminectomy and fusion based on an absence of clear rationale for including the L4/5 level and no documentation of smoking status. The 2/14/14 treating physician appeal cited back and radiating leg pain and weakness that had progressed. Significant limitation in activities of daily living was documented.

The patient was a non-smoker. MRI and x-ray findings demonstrated retrolisthesis of L4-L5, sub-articular stenosis, and advanced degenerative disc disease of this segment. The treating physician opined that the patient would benefit from a two-level fusion at L4/5 and L5/S1 and that there was a chance of suboptimal outcome leaving the L4/5 segment alone and a greater risk of having activity limitation in the future. Physical exam documented antalgic gait, cane use for ambulation, lumbar range of motion 40-50% of normal, and lumbosacral junction tenderness. There is decreased lateral calf sensation and diminished ankle dorsiflexion and great toe extension strength. X-rays performed 1/22/14 documented marked angular and translational instability. The treatment plan recommended laminectomy and fusion at L5/S1 with inclusion of L4/5 if able to obtain authorization. Otherwise, a single level fusion would be performed.

IMR ISSUES, DECISIONS AND RATIONALES

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

OUTPATIENT SURGERY: LUMBAR 4-5, LUMBAR 5-SACRAL 1 LAMINECTOMY AND FUSION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar and Thoracic, Fusion (spinal).

Decision rationale: The ACOEM revised low back guidelines state that lumbar fusion is recommended as an effective treatment for degenerative spondylolisthesis. 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 neurological dysfunction. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Spinal instability criteria includes lumbar inter segmental movement of more than 4.5 mm. 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 clear evidence of spinal instability consistent with guideline criteria of more than 4.5 mm. There is no detailed documentation that recent comprehensive pharmacological and non-pharmacological conservative treatment had been tried and failed. A psychosocial screen is not evidenced. Therefore, this request for outpatient surgery, L4/5 and L5/S1 laminectomy and fusion, is not medically necessary.