

Case Number:	CM14-0029067		
Date Assigned:	06/16/2014	Date of Injury:	06/10/2011
Decision Date:	07/21/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/06/2014

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 patient is a 42 year old male who was injured on 06/11/2011 when he fell on his back while he was carrying a bucket with gravel. Diagnostic studies reviewed include MRI of the pelvis without contrast on 02/13/2014 revealed bilateral mild sacroiliac joint degenerative disease. MRI of the lumbar spine on the same date showed disc desiccation at the L4-L5 and S1 levels; right disc herniation at the L5-S1 level effacing the anterior epidural fat and resulting in overall moderate spinal canal stenosis. There is also disc osteophyte and mild facet arthropathy changes causing mild to moderate foraminal stenosis. At the L4-L5 level, there is also disc bulging and mild facet arthropathy changes with borderline spinal canal stenosis. The MRI is compared to a prior study of 08/03/12, performed at [REDACTED] and there appears to be no improvement in the disc herniation at L5-S1. The patient underwent EMG and nerve conduction velocity studies of the lower extremities on 12/02/2013 which reportedly revealed findings consistent with chronic bilateral S1 radiculopathy which correspond with the patient's symptoms. On SOAP note dated 03/18/2014, the patient complained of pain with associated weakness in the right foot and numbness of the right calf, right leg and right foot. He reported the pain is constant. He rated his pain as a 6/10. His activities of daily living are limited because of his pain. Objective findings on exam revealed the patient to ambulate without an assistive device. The lumbar spine revealed range of motion exhibits forward flexion to 50 degrees, extension to 20 degrees, and side bending to 20 degrees to the right and 20 degrees to the left. His rotation is limited. He also had tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with spasms. There is sciatic notch tenderness and positive lumbar facet loading maneuver bilaterally. Straight leg raise test is positive bilaterally. Motor strength is 5/5. Sensation is diminished bilaterally at L5 and S1 dermatomes of her lower extremities. Diagnosis is lumbar intervertebral disc without myelopathy. The plan included conservative treatment for

low back pain. Neurosurgical report dated 02/17/2014 reports the patient presented with ongoing low back pain and radicular right leg pain. Diagnostic impressions are a large intervertebral disc herniation, L5-S1 on the right, with right S1 radiculopathy confirmed on EMG, 2) intervertebral disc herniation, L4-L5 3) sacroilitis and 4) radiculopathy. The treatment and plan included a bilateral laminotomy and foraminotomy for nerve root decompression at the L4-L5 and L5-S1 levels combined with discectomy and posterior interbody fusion with implantation of fusion cages and posterior instrumentation with interspinous fixation devices and posterolateral fusion to stabilize the spine. Prior utilization review dated 02/28/2014 states the request for bilateral laminotomy and foraminotomy at L4-5 and L5-S1, posterior lumbar interbody fusion at L4-5 and L5-S1, cages, L4-5 and L5-S1, instrumentation, posterolateral fusion L4-5 and L5-S1; microsurgical tech is denied as there is no evidence to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL LAMINOTOMY AND FORAMINOTOMY AT L4-5 AND L5-S1, POSTERIOR LUMBAR INTERBODY FUSION AT L4-5 AND L5-S1, CAGES, L4-5 AND L5-S1, INSTRUMENTATION, POSTEROLATERAL FUSION L4-5 AND L5-S1; MICROSURGICAL TECH: 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): 310. Decision based on Non-MTUS Citation ODG, Low Back, Fusion.

Decision rationale: According to the California MTUS guidelines, Disk surgery is not recommended for low back pain alone with no red flags and no nerve compression. The MRI dated 2/13/2014 confirms disc herniation at multiple levels, but that does not confirm the presence of nerve root compression. On the other hand, fusion of the lumbar spine is not recommended in the absence of fractures, dislocations, complications of tumor or infections. As per the ODG guidelines, lumbar spine 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. Moreover; pre-operative clinical surgical indications for spinal fusion should include all of the following: all pain generators are identified and treated; all physical medicine and manual therapy interventions are completed; x-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography and MRI demonstrating disc pathology correlated with symptoms and exam findings; spine pathology limited to two levels; psychological screen with confounding issues addressed. For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. The medical records do not address the presence of spinal instability. Furthermore, the PR2 dated 2/12/2014 indicates that the patient has not completed his course of physical therapy although he reported that was beneficial. There is nothing in the medical records refers to the failure of the conservative measurements including PT and Manipulations. Accordingly, the medical necessity of the Bilateral Laminotomy and Foraminotomy at L4-L5 and L5-S, Posterior Lumbar Interbody

Fusion at L4-L5 and L5-S1, Cages at L4-L5 and L5- S1, Instrumentation, Posterolateral Fusion at L4-5 and L5-S; Microsurgical Tech has not been established.