

Case Number:	CM14-0045447		
Date Assigned:	06/27/2014	Date of Injury:	11/18/2008
Decision Date:	11/04/2014	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	04/01/2014

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 61-year-old male who reported an injury on 11/18/2008. The mechanism of injury was not provided. The documentation of 03/28/2014 revealed the injured worker underwent a laminectomy in 2012. The injured worker had significantly improved right sided buttock and leg pain. The injured worker had markedly increased pain in the shins, and tops and bottoms of the feet. The prior treatments were noted to include physical therapy, acupuncture, chiropractic treatment, and lumbar injections before and after the laminectomy. The injured worker had 1 epidural steroid injection postsurgically which was not helpful. The injured worker's medications were noted to include OxyContin and Lyrica. The injured worker had urinary hesitancy, weakness of the stream, and difficulty emptying his bladder. The physical examination revealed the injured worker had 5/5 strength in the iliopsoas, quadriceps, hamstrings, plantar flexors, dorsiflexors, and extensor hallucis longi, with no atrophy. The deep tendon reflexes were 1+ in the ankle jerks. The injured worker's reflexes were 2+ in the quadriceps. Heel walking was difficult for the injured worker on the left where there was quite a bit of giveaway. The injured worker had normal range of motion in flexion, extension, and lateral rotation bilaterally. The injured worker had x-rays of the lumbar spine including flexion and extension views. In neutral view, there was grade 1 spondylolisthesis in L4-5, and it was not seen on the supine MRI. This increased more than 5 mm in flexion, and reduced to a normal alignment in extension, consistent with L4-5 instability. There was development of anterolisthesis of L4 on L5 with a 0.7 cm instability between flexion and extension. The injured worker had an MRI of the lumbar spine on 09/25/2013. Per the physician documentation of the MRI, the injured worker had an old chronic L2 compression fracture without residual edema. There was minimal disc degeneration of the upper lumbar discs. There was mild to moderate degeneration of L4-5 and moderate degeneration of L5-S1. At L4-5, there were postoperative

changes with significant residual bilateral facet hypertrophy as well as broad based disc protrusion resulting in severe bilateral lateral recess stenosis. There was a moderate bilateral foraminal stenosis due to foraminal disc protrusion. At L5-S1 there was moderate left foraminal stenosis due to foraminal disc protrusion and vertical foraminal height loss, along with moderate bilateral lateral recess stenosis. There was no high grade canal stenosis at any level. The impression included the injured worker had pain that was worsening and was disabling in the low back bilateral shin and foot. The physician further documented the imaging demonstrated gross instability at L4-5, along with residual disc herniation and stenosis, and at L5-S1 the injured worker had degenerative disc space changes, lateral recess and foraminal stenosis. The physician opined the findings at L4-5 with potential contribution from L5-S1 correlate with the symptoms. The physician documented in this situation, surgery would require an L4-5 decompression and transforaminal lumbar interbody fusion, with pedicle screw instrumentation, with decompression and fusion at L5-S1. The documentation further indicated the injured worker was primarily symptomatic from L4-5, and a fusion was mandated due to gross instability, and the injured worker required significant further extensive decompression that would only further destabilize him. The physician opined the level of L5-S1 should not be left untreated to a fused motion segment above, given the extent of the degeneration present at that level. Additionally, the physician documented the injured worker had nerve root compression at L5-S1, further adding and contributing to the symptoms of plantar foot pain. The recommendation was for an L4-5 and L5-S1 transforaminal lumbar interbody fusion with pedicle screw instrumentation. It was noted the injured worker would need a CT scan preoperatively to definitively evaluate the areas of bony decompression from the old laminectomy. The documentation of 02/19/2014 revealed the injured worker should have an L2 through S1 instrumented fusion and decompression. Due to the fracture at L2, there would need to be stabilization to prevent further height loss or kyphosis, as there already existed a wedge compression deformity at L2. There was a detailed Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-S1 Posterior approach for instrumented fusion: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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.

The clinical documentation submitted for review indicated the injured worker had x-rays which revealed grade 1 spondylolisthesis with an increase of more than 5 mm in flexion that was reduced to a near normal alignment in extension, consistent with an L4-5 instability. There was the development of anterolisthesis of L4 on L5 with a 0.7 cm instability between flexion and extension. There was no high grade canal stenosis at any level per the MRI of 09/25/2013. However, the MRI revealed a development of anterolisthesis of L4 on L5 with a 0.7 cm instability between flexion and extension. There was a lack of documentation of a psychological screening. There was a lack of documentation indicating the injured worker had a relative angular motion greater than 20 degrees or intersegmental movement of more than 4.5 mm. The documentation indicated that the injured worker would need a CT scan preoperatively to definitively evaluate the areas of bony decompression from the old laminectomy. The findings were not noted. The procedure was noted to be requested with a discectomy, which if approved would produce iatrogenic instability, and this request would be supported. However, the discectomy portion was not supported. Given the above, the request for L3-S1 Posterior approach for instrumented fusion is not medically necessary.

Additional levels L3-S1 Posterior approach for instrumented fusion x 3: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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. The clinical documentation submitted for review indicated the injured worker had x-rays which revealed grade 1 spondylolisthesis with an increase of more than 5 mm in flexion that was reduced to a near normal alignment in extension, consistent with an L4-5 instability. There was the development of anterolisthesis of L4 on L5 with a 0.7 cm instability between flexion and extension. There was no high grade canal stenosis at any level per the MRI of 09/25/2013. There was a lack of documentation of a psychological screening. There was a lack of documentation indicating the injured worker had a relative angular motion greater than 20 degrees or intersegmental movement of more than 4.5 mm. The documentation indicated that the injured worker would need a CT scan preoperatively to definitively evaluate the areas of bony decompression from the old laminectomy. The findings were not noted. The procedure was noted to be requested with a discectomy, which if approved would produce iatrogenic instability,

and this request would be supported. However, the discectomy portion was not supported. Given the above, the request for Additional levels L3-S1 Posterior approach for instrumented fusion x 3 is not medically necessary.

L3-S1 Decompression: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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. The clinical documentation submitted for review failed to indicate the injured worker had myotomal or dermatomal findings to support the necessity for intervention. There was a lack of documentation of EMG and nerve conduction studies. Given the above, the request for L3-S1 Decompression is not medically necessary.

Additional Levels L3-S1 Decompression x3: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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. The clinical documentation submitted for review failed to indicate the injured worker had myotomal or dermatomal findings to support the necessity for intervention. There was a lack of documentation of EMG and nerve conduction studies. Given the above, the request for Additional Levels L3-S1 Decompression x3 is not medically necessary.

Placement of Instrumentation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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. The clinical documentation submitted for review indicated the injured worker had x-rays which revealed grade 1 spondylolisthesis with an increase of more than 5 mm in flexion that was reduced to a near normal alignment in extension, consistent with an L4-5 instability. There was the development of anterolisthesis of L4 on L5 with a 0.7 cm instability between flexion and extension. There was no high grade canal stenosis at any level per the MRI of 09/25/2013. There was a lack of documentation of a psychological screening. There was a lack of documentation indicating the injured worker had a relative angular motion greater than 20 degrees or intersegmental movement of more than 4.5 mm. The documentation indicated that the injured worker would need a CT scan preoperatively to definitively evaluate the areas of bony decompression from the old laminectomy. The findings were not noted. The fusion was found to be not medically necessary. Additionally, the request as submitted failed to indicate the level for the placement of instrumentation. The request for Placement of Instrumentation is not medically necessary.

One (1) box of island Bandages: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Physical Therapy visits 3 x 6: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.