

Case Number:	CM14-0046098		
Date Assigned:	06/27/2014	Date of Injury:	03/28/2007
Decision Date:	07/31/2014	UR Denial Date:	03/17/2014
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 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 sustained an industrial injury on 3/26/07 while squatting. He underwent right L5/S1 microdiscectomy on 3/18/08 with relief of low back and right lower extremity pain and was able to return to work. He reported a re-injury on 9/30/13 with onset of low back and right leg pain and was unable to work. The 11/11/13 lumbar MRI impression documented post-surgical changes at L5/S1 with scar tissue in the thecal sac minimally encroaching on the right S1 nerve root. There was a desiccated L4/5 disc bulge resulting in severe central and lateral recess stenosis. Severe stenosis was noted at L2/3. The 1/10/14 neurosurgical report documented low back and right lower extremity pain. Objective findings documented decreased range of motion, 5/5 lower extremity strength, 2+ and symmetrical deep tendon reflexes, intact sensation, and negative straight leg raise. Flexion/extension views and a CT myelogram were planned. On 3/31/14, the neurosurgeon documented that the 3/3/14 CT myelogram showed a large right L4/5 herniated nucleus pulposus with compression on the nerve root in the thecal sac. There was severe facet arthropathy at L5/S1 with nerve root compression. The patient felt he was getting worse. No exam findings were documented. A right L4/5 and L5/S1 redo laminectomy and posterolateral instrumented fusion was recommended. Records indicated that the patient was a cigar smoker with history of pulmonary hypertension versus chronic obstructive pulmonary disease resulting in nighttime and exertional oxygen dependency. The 3/17/14 utilization review denied the surgical request based on an absence of clinical evidence of objective radiculopathy, segmental instability, tumor or infection. Conservative treatment had not been exhausted, as no injections were undertaken. The 3/23/14 patient appeal letter stated that he had injured his back again on 9/30/13 and that the independent examiner said that he would need future surgery. He wanted to have the surgery so he could get back to work.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient Right L4-5 and L5-S1 Posterior Oblique Arthrodesis with ReDo Laminectomy and Posterolateral Instrumentation and Fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in workers Comp 18th edition, 2013 Updates, Low Back Chapter Fusion (spinal).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (Spinal).

Decision rationale: The ACOEM revised low back guidelines state that lumbar fusion is not recommended as a treatment for patients with radiculopathy from disc herniation or for patients with chronic lower back pain after lumbar discectomy. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability or deformity has been proven. The Official Disability Guidelines recommend criteria for decompression surgery (lumbar discectomy and laminectomy) that includes symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Fusion is recommended for objectively demonstrable segmental instability. 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. For any potential fusion surgery, it is recommended that the patient refrain from smoking for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been met. There is no current objective clinical evidence confirmed the presence of radiculopathy and correlated with imaging findings. There is no radiographic evidence of segmental instability. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. There is no documentation of successful smoking cessation. A psychosocial screen is not evidenced. Therefore, this request for inpatient right L4-5 and L5-S1 posterior oblique arthrodesis with redo laminectomy and posterolateral instrumentation and fusion is not medically necessary.