

Case Number:	CM14-0047830		
Date Assigned:	06/25/2014	Date of Injury:	11/05/2003
Decision Date:	07/23/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	03/28/2014

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 64-year-old male sustained an industrial injury on 11/3/03, when he lifted a cleaning machine with onset of lower back pain. Past medical history was significant for cardiac stent surgery in 2012. The 1/16/14 lumbar MRI impression documented an L3/4 disc bulge with mild bilateral neuroforaminal narrowing. There was an L4/5 circumferential disc bulge with moderate bilateral neuroforaminal narrowing, moderate central canal stenosis, and bilateral facet joint hypertrophy with ligamentum flavum redundancy. At L5/S1, there was a circumferential disc bulge with severe bilateral neuroforaminal narrowing, likely impingement of the bilateral exiting nerve roots, moderate central canal stenosis, and bilateral fact joint hypertrophy. The 2/13/14 treating physician report cited constant, moderate to severe back and bilateral leg pain. The patient required a walker with a seat to ambulate. Activities of daily living were significantly affected. Multiple falls were reported secondary to numbness and tingling in the legs. Physical exam documented antalgic gait, abnormal toe/heel walk, thoracolumbar paraspinal tenderness, lumbar muscle spasms, and limited lumbar range of motion in all planes. There was decreased L5 and S1 dermatomal sensation, and positive bilateral straight leg raise. Flexion/extension x-rays showed severe disc space narrowing at L5/S1, and syndesmophytes at L2/3 and L5/S1. The patient had failed conservative treatment, including lumbar epidural injections, physical therapy, rest, and medications. Anterior and posterolateral lumbar interbody fusion with decompression at L4/5 and L5/S1 was recommended. The 3/17/14 utilization review denied the request for lumbar fusion and associated services as there was no evidence that the patient had undergone pre-surgical psychological evaluation. The 3/21/14 treating physician appeal letter stated that the patient failed to demonstrate long term benefit and/or functional improvement with extensive conservative treatment. Imaging clearly indicated the patient had lumbar stenosis, lumbar disc protrusion, and radiculopathy. The treating physician reviewed the clinical exam and imaging

findings, and discussed how guideline criteria had been met. There was no documentation of a psychological evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterolateral Lumbar Fusion at the levels L4-L5, L5-S1 with Screw, Allograft and Bilateral Decompression: 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): 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 Disorder guidelines recommend decompression surgery as an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability has been proven. The Official Disability Guidelines recommend criteria for lumbar discectomy and laminectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Fusion may be supported for surgically induced segmental instability but pre-operative guidelines recommend completion of all physical medicine and manual therapy interventions and psychosocial screen with all confounding issues addressed. Guideline criteria have not been met. The presence of moderate spinal canal stenosis at L4/5 and L5/S1 would likely require complete laminectomy which would result in surgically induced segmental instability. The patient has failed guideline-recommended conservative treatment. However, there is no evidence of a psychosocial screen as required by guidelines. Therefore, this request for posterolateral lumbar fusion at the levels L4-L5, L5-S1 with screw, allograft and bilateral decompression is not medically necessary.

Anterior Lumbar Interbody Fusion at the level of L4-L5 and L5-S1 with Cages and Allograft: 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): 209-211.

Decision rationale: The ACOEM Revised Low Back Disorder guidelines recommend decompression surgery as an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management. Lumbar fusion is not

recommended as a treatment for spinal stenosis unless concomitant instability has been proven. The Official Disability Guidelines recommend criteria for lumbar discectomy and laminectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Fusion may be supported for surgically induced segmental instability but pre-operative guidelines recommend completion of all physical medicine and manual therapy interventions and psychosocial screen with all confounding issues addressed. Guideline criteria have not been met. The presence of moderate spinal canal stenosis at L4/5 and L5/S1 would likely require complete laminectomy which would result in surgically induced segmental instability. The patient has failed guideline-recommended conservative treatment. However, there is no evidence of a psychosocial screen as required by guidelines. Therefore, this request for anterior lumbar interbody fusion at the level of L4-L5 and L5-S1 with cages and allograft is not medically necessary.

(1) Vascular Surgeon: 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.

2 Day Inpatient Hospital Stay: 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.