

Case Number:	CM14-0055040		
Date Assigned:	07/07/2014	Date of Injury:	10/03/1996
Decision Date:	08/25/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	04/24/2014

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 injured worker is a 51-year-old male who reported injury on 10/03/1996. The diagnoses was spinal stenosis, lumbar, without neurogenic claudication. The mechanism of injury was the injured worker was caught between a forklift and a commercial building. The injured worker underwent an L5-S1 laminectomy in 2000 and an anterior fusion. The injured worker underwent a subsequent anterior L5-S1 interbody fusion on 06/19/2002 when he had a collapse of the disc space. The injured worker underwent a CT of the lumbar spine without contrast on 02/12/2014, which revealed the patient had diffuse disc bulge with ligamentum flavum, hypertrophy causing mild to moderate canal stenosis and mild to moderate bilateral exit foramen narrowing, unchanged from prior CT and at the level of L5-S1 there was again seen a metallic disc cage for the fusion at L5-S1 and there was no fusion anterior and posterior to the disc cage. There was persistent lucency seen inferior to the metallic disc cage in the central aspect of the S1 vertebrae. The physician opined these changes could be from possible pseudoarthrosis. This was noted to be unchanged from the prior CT. There was noted to be persistent central to left anterior margin bridging osteophyte at L5-S1. The examination was noted to be unchanged from the prior examination. The injured worker underwent an x-ray of the lumbosacral spine 02/12/2014 which revealed lucency centrally within the S1 vertebrae in intimate relation and just inferior to the metallic disc cage at L5-S1 which could suggest hardware loosening. The documentation of 02/18/2014 revealed the injured worker had a continuance of bilateral leg pain and was more symptomatic on the right than the left. The injured worker was noted to be unable to stand more than 5 minutes or walk more than several blocks without sitting and leaning forward. The prior treatments included steroid injections. Physical examination revealed the injured worker had a positive sciatic nerve stretch test on the left at 80 degrees and on the right at 45 degrees. The deep tendon reflexes were 1+ at the bilateral knees and ankles. There was decreased sensation of

the right L4 and L5 dermatome. The impression was L3-L4 and L4-L5 spinal stenosis with electrophysiologic evidence of an L5 radiculitis. The treatment plan included a bilateral L4-L5 transforaminal epidural steroid injection and a simple L3-L4 and L4-L5 laminectomy and a right L5-S1 foraminotomy. The subsequent documentation dated 04/07/2014 revealed the injured worker was being treated with Percocet 5/325 and had an epidural steroid injection with excellent relief at the level of L4-L5. The physical examination revealed the sciatic nerve stretch test reproduced left leg pain at 60 degrees. The sciatic nerve stretch test was positive on the right at 40 degrees. The calf circumference was 14.5 on the right and 15.5 on the left. The deep tendon reflexes were 1+ at the bilateral knees and ankles. There was decreased sensation on the right L4 and L5 dermatome. The diagnoses included L4-L5 spinal stenosis with neurogenic claudication, foraminal stenosis and right L4 radiculitis and painful pseudoarthrosis at L5-S1. The treatment plan included the injured worker had exhausted all conservative care and was a candidate for posterior L4-L5 laminectomy and foraminotomy combined with a transforaminal interbody fusion using a PEEK cage filled with local bone. The pseudoarthrosis at L5-S1 would be treated with a posterior fusion and instrumentation using local bone. The physician opined that an L4-L5 and L5-S1 transpedicular fixation construct would increase the chance of the fusion becoming solid and minimize postoperative morbidity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior L4-5 laminectomy, transforaminal interbody fusion at L4-5 with peek cage filled with bone morphogenic protein; posterior L5-S1 fusion with local bone & posterior segmental fixation L4-5 & L5-S1 with 3 days in -patient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM -<https://www.acoempracguides.org/> low back; table 2, summary of recommendations, low back disorders.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Hospital Length of Stay.

Decision rationale: The ACOEM Guidelines indicate a surgical consultation is appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging, preferably with accompanying signs of neurocompromise. There should be documentation of activity limitation due to radiating leg pain for more than 1 month or extreme progression of lower leg symptoms. There should be clear clinical, imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. There should be documentation of the failure of conservative treatment to resolve disabling radicular symptoms. Additionally they indicate that 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. The clinical documentation submitted for review failed to provide documentation of spinal instability or document necessity for a fusion. The CT scan revealed the injured worker had mild to moderate stenosis at the level of L4-L5, along with signs and

symptoms of spinal stenosis which may support the need for a laminectomy. It would not support the need for a Transforaminal interbody fusion. This portion of the request would not be supported. The CT revealed non-fusion with the metallic disc cage for fusion at the level of L5-S1. These were changes which were opined to possibly be due to pseudoarthrosis. The prior surgical intervention and presumably pseudoarthrosis happened over ten years ago. There was a lack of documentation as to why the injured worker was symptomatic now. The request for the posterior L5-S1 fusion with local bone would not be supported. As not all of the requested procedures are medically necessary, the request for the posterior segmental fixation at L4-L5 and L5-S1 would not be supported. The California MTUS/ACOEM Guidelines do not specifically address hospital length of stay. As such, secondary guidelines were sought. The Official Disability Guidelines indicate the best practice target is 3 days for a fusion. This request would be supported if the fusion was supported. Given the above, the request for a posterior L4-5 laminectomy, transforaminal interbody fusion at L4-5 with peek cage filled with bone morphogenic protein; posterior L5-S1 fusion with local bone & posterior segmental fixation L4-5 & L5-S1 with 3 days in -patient stay is not medically necessary.