

Case Number:	CM14-0076893		
Date Assigned:	07/18/2014	Date of Injury:	05/13/1993
Decision Date:	08/25/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	05/27/2014

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 Texas, Montana and Tennessee. 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 58-year-old male who reported an injury on 05/13/1993. Prior surgeries included a laminectomy and a spinal cord implant. Prior treatments included epidural steroid injections and home exercise. The injured worker underwent a CT myelogram with contrast on 03/05/2014, which revealed surgical changes of laminotomies at L2 and laminectomies from L3-L4. There was evidence of prior hardware from L3-L5. There was a solid osseous fusion at L3-L4 and L4-L5 with no evidence of osseous malalignment. At L3 and L4 there was mild degenerative disc disease with ossification of the intervertebral discs. At L4 and L5 there was no significant central canal stenosis. There was moderate to severe left neuroforaminal narrowing at L5-S1 which appears progressed compared with prior CT of the lumbar spine on 06/14/2012. The impression revealed no evidence of significant central canal stenosis. Surgical changes as previously listed were unchanged. There was interval progression of moderate to severe neuroforaminal narrowing on the left at L5-S1. The documentation of 04/09/2014 revealed the injured worker had a transforaminal epidural steroid injection at L5-S1 with short term relief. The physical examination revealed motor strength of 5/5. Deep tendon reflexes were absent and symmetric at the knees as well as at the ankles. Bilateral straight leg raise for reproduction of posterior leg pain was positive sitting at 40 degrees. The impression/diagnoses included, back and radiating leg pain, degenerative discs and stenosis. It was opined the injured worker had appropriate non-operative care with progressive leg symptoms and back pain. The injured worker had stenosis at L5-S1 and disc changes at L2-L3 with flat back deformity. The requested staged surgical procedure was L2-3 and L5-S1 laminectomy and insertion of screws at L2-S1 on same day, then on second day follow with retroperitoneal approach for L5-S1 anterior discectomy and interbody fusion and extreme lateral interbody fusion (XLIF) at L2-3 and then complete posterior instrumented fusion L2-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

L2-L3 and L5-S1 laminectomy and insertion of screws at L2-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The ACOEM guidelines indicate that 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, preferably with accompanying objective signs of neurocompromise. 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. There should be clear clinical, imaging and electrophysiological 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 a failure of conservative treatment to resolve disabling radicular symptoms. The physical examination submitted for review indicated the injured worker's deep tendon reflexes were absent and symmetric at the knees as well as at the ankles and the injured worker had a bilateral straight leg raise that reproduced, posterior leg pain at 40 degrees sitting bilaterally. However, the injured worker's motor strength was 5/5. The clinical documentation submitted for review indicated the injured worker had no findings of nerve compression upon the CT scan. As such, there was a lack of documentation of nerve root compression, lateral disc rupture or lateral recess stenosis. There was no electrophysiological evidence submitted for review. Given the above, the request for L2-L3 and L5-S1 laminectomy and insertion of screws at L2-S1 is not medically necessary.

Retroperitoneal approach for L5-S1 anterior discectomy and interbody fusion and XLIF L2-3 and then complete posterior instrumented fusion L2-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The ACOEM guidelines indicate that 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, preferably with accompanying objective signs of neurocompromise. 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. There should be clear clinical, imaging and electrophysiological 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 a failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the injured worker had no findings of nerve compression upon the CT scan. The physical examination submitted for review indicated the injured worker's deep tendon reflexes were absent in symmetric at the knees as well as at the ankles and the injured worker had a bilateral straight leg raise that reproduced, posterior leg pain at 40 degrees sitting bilaterally. However, the injured worker's motor strength was 5/5. As such, there was a lack of documentation of nerve root compression, lateral disc rupture or lateral recess stenosis. There was no electrophysiological evidence submitted for review. The ACOEM Guidelines further indicate that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back pain in the absence of spinal fracture, dislocation or spondylolisthesis if there is instability in motion in the segment operated on. The clinical documentation submitted for review failed to provide that there was motion on the segment that was to be operated on. There was a lack of documentation indicating a necessity for a fusion from L2 through S1. Given the above, the request for retroperitoneal approach for L5-S1 anterior discectomy and interbody fusion and XLIF L2-3 and then complete posterior instrumented fusion L2-S1 procedure is not medically necessary.