

Case Number:	CM14-0080214		
Date Assigned:	07/18/2014	Date of Injury:	08/12/2009
Decision Date:	10/08/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	05/30/2014

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 50-year-old female who reported an injury on 08/12/2009. The mechanism of injury was not provided in the medical records. She is diagnosed with L5-S1 disc herniation with spondylolisthesis. Her past treatments were noted to include medications, topical analgesics, participation in a home exercise program, physical therapy, activity modification, and epidural steroid injections. An MRI of the lumbar spine was performed on 01/25/2014 and was noted to reveal a 7 mm to 8 mm anterolisthesis at L5-S1 related to a bilateral L5 pars defect, as well as small diffused disc bulging extenuating by the uncovering of the disc, moderate foraminal narrowing on the right and moderate to severe foraminal narrowing on the left, and encroachment on the left L5 nerve root. At the L4-5 level, there was a 1 mm broad based disc bulge with a small annular fissure and no significant foraminal stenosis. Surgical history was not indicated. On 04/21/2014, the injured worker presented with complaints of severe low back pain, as well as pain in her neck, waist, back, hands, legs, and ankle. It was noted that she had received a lumbar epidural steroid injection the previous week, which had not alleviated her pain in any way. She also denied benefit from use of Cyclobenzaprine, which she was taking in addition to Naproxen, Hydrocodone, and Lisinopril. Her physical examination revealed a diminished ankle jerk reflex on the left side, decreased plantar strength on the left and decreased sensation to the postural lateral foot and heel on the left side. She was also noted to have a positive straight leg raise on the left. The treatment plan included an L4-5 and L5-S1 anterior lumbar antibody fusion with posterior spinal fusion. The surgery was recommended based on the injured worker's complaints of left leg radicular symptomology and consistent findings on MRI, as well as failed conservative treatment. The Request for Authorization form was not submitted in the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 degree fusion and L5-S1 anterior lumbar interbody fusion w/posterior spinal fusion:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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, Fusion (spinal)

Decision rationale: According to the California MTUS/ACOEM Guidelines, spinal surgery may only be considered when serious spinal pathology and/or nerve root dysfunction has been unresponsive to at least 3 months of conservative therapy and is obviously due to a herniated disc. Documentation should show: severe and disabling radiating symptoms in a distribution consistent with abnormalities on imaging studies, as well as accompanying objective signs of neural compromise; activity limitations due to radiating extremity pain that have been present for more than 1 month, or an extreme progression of radiating symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit from surgical repair; and the failure of at least 3 months of conservative treatment to resolve disabling radicular symptoms. Additionally, the guidelines state that spinal fusion may be considered when there is clear evidence of instability. More specifically, the Official Disability Guidelines state that lumbar spinal fusion should not be considered within the first 6 months of symptoms except when there is evidence of fracture, dislocation, or progressive neurologic loss. The guidelines state that indications for spinal fusion may include: a neural arch defect with spondylolytic spondylolisthesis or congenital neural arch hypoplasia; objectively demonstrable segmental instability; primary mechanical back pain with failure of functional spinal unit and instability; when revision surgery is performed for failed previous operations if significant functional gains are anticipated; when there is infection, tumor, or deformity of the lumbosacral spine that causes intractable pain, neurological deficit, and functional disability; or after the failure of 2 discectomies on the same disc. Additionally, the guidelines state that prior to spinal fusion, all pain generators need to be identified and treated; all physical medicine and manual therapy intervention has been tried and failed; x-rays have demonstrated spinal instability, and MRI or other diagnostic testing has demonstrated disc pathology which has been correlated with symptoms and physical examination findings; the spinal pathology is limited to 2 levels; psychosocial screening has been performed and confounding issues have been addressed; and recommendations have been made for patients who smoke to refrain from smoking for at least 6 weeks prior to surgery and during the period of fusion healing. The injured worker was noted to have low back pain with radiating symptoms into left lower extremity. She was noted to have neurological deficits in the left lower extremity as well, including a positive straight leg raise, diminished ankle jerk reflex, decreased plantar strength, and decreased sensation in the postural lateral foot and heel. Additionally, she was noted to have significant findings on MRI of an anterolisthesis at the L5-S1 level related to bilateral L5 pars defect, moderate foraminal narrowing on the right, and moderate to severe foraminal narrowing on the left with encroachment on the left L5 nerve root. She also had a 1 mm disc broad based disc bulge with small annular fissure at the L4-5 level. Additionally, the injured worker was noted to have failed conservative treatment with physical therapy, medications, and epidural steroid injections, her symptoms are noted to be

present longer than 6 months, and conservative treatment was attempted. Additionally, upon comparison of her physical examination on 12/6/2013, she was noted to have progressive neurological deficits as her examination of the lumbar spine at that time had revealed negative straight leg raising and there was no documentation of other neurological deficits. However, the documentation failed to show clear neurological deficits in an L4-5 distribution and the injured worker only had mild pathology at this level, with no evidence of neural foraminal narrowing. Therefore, despite correlation with her symptoms, objective findings, and MRI findings of radiculopathy related to the L5-S1 level, there was insufficient documentation to show significant radiculopathy originating from the L4-5 level. Moreover, the documentation failed to provide evidence of electrodiagnostic studies, a psychosocial screening which had addressed confounding issues, and documentation showing that the injured worker had been advised to refrain from smoking for at least 6 weeks prior to the surgery and during the period of fusion healing, if applicable. In summary, in the absence of documentation showing radiating symptoms in a distribution consistent with abnormalities at the L4-5 level and accompanying objective signs of neural compromise at this level, the requested surgical intervention at L4-5 is not supported. In addition, in the absence of documentation showing electrodiagnostic study evidence of radiculopathy related to the L5-S1 level, a psychological evaluation, and documentation regarding the need to refrain from smoking, the surgical procedure at the L5-S1 is also not supported. For the reasons noted above, the request is not medically necessary.

Physical Therapy twice weekly for 4 weeks: 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.

Inpatient stay days: 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.