

Case Number:	CM14-0199076		
Date Assigned:	12/08/2014	Date of Injury:	10/11/2012
Decision Date:	01/30/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/25/2014

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, has a subspecialty in Fellowship Trained in Spine Surgery and is licensed to practice in Georgia. 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 54-year-old female smoker who reported an injury due to a trip and fall on 10/11/2012. On 10/28/2014, her diagnoses included spinal/lumbar degenerative disc disease, lumbar facet syndrome, sacroiliac pain, and lumbar radiculopathy. Her complaints included fluctuating pain along her lower back depending upon her activity level, with muscle spasms, numbness, tingling, and weakness. She reported that her medications reduced her pain level with minimal side effects and allowed her to perform ADLs, such as cooking, cleaning, and shopping, with increased endurance and tolerance. She rated her pain at 4/10 with medications and 8/10 without. She also included applications of heat and ice, stretching, and relaxation techniques into her daily regimen. Upon examination, there was spasm and tenderness noted on the bilateral paravertebral muscles of the lumbar spine with bilateral sacroiliac joint tenderness. She had a positive Gaenslen's, facet loading tests, and straight leg raising test at 45 degrees. An MRI of the lumbar spine on 04/15/2014 revealed at L4-5, there was 2 mm of anterolisthesis with endplate changes extending into the posterior elements along with facet hypertrophy. There was a small disc bulge and facet and ligamentum flavum hypertrophy with mild central canal narrowing and mild bilateral neural foraminal narrowing. At L5-S1, a 2 mm annular disc bulge extended into the neural foramina on the right with moderate neural foraminal narrowing. X-rays of the lumbar spine on 05/16/2014 revealed mild chronic superior endplate compression deformities at L1 and L3, 3 mm L4-5 anterolisthesis without evidence of instability or spondylolysis, mild L4-5 and moderate L5-S1 degenerative disc disease and lower lumbar facet arthropathy. The rationale for the requested surgery was that the practitioner discussed surgical intervention versus continued pain management. This injured worker reportedly wished to proceed with surgical intervention. A bone mineral density test was requested prior to the surgery. There was no Request for Authorization included in this worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 Decompression, Transforminal Lumbar Interbody Fusion: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307, 310.

Decision rationale: The request for L4-L5 Decompression, Transforminal Lumbar Interbody Fusion is not medically necessary. The California ACOEM Guidelines note that within the first 3 months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy (and obviously due to a herniated disc) is detected. Disc herniation may impinge on a nerve root, causing irritation, back and leg symptoms, and nerve root dysfunction. The presence of a herniated disc on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disc herniations that apparently do not cause symptoms. Some studies suggest that pain may be due to irritation of the dorsal root ganglion by inflammogens released from a damaged disc in the absence of anatomical evidence of direct contact between neural elements and disc material. Therefore, referral for surgical consultation is indicated for patients who have: severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than 1 month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair; and failure of conservative treatment to resolve disabling radicular symptoms. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as the MMPI 2. With or without surgery, more than 80% of patients with apparent surgical indications eventually recover. Surgery benefits fewer than 40% of patients with questionable physiologic findings. Moreover, surgery increases the need for future surgical procedures with higher complication rates. In good surgery centers, the overall incidence of complications from first time disc surgery is less than 1%. However, for older patients and repeat procedures, the rate of complications is dramatically higher. Except for cases of trauma related spinal fracture or dislocation, fusion of the spine is not usually considered during the first 3 months of symptoms. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. 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. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the

patient. A recent study has shown that only 29% assessed themselves as "much better" in the surgical group versus 14% "much better" in the nonfusion group (a 15% greater chance of being "much better") versus a 17% complication rate (including 9% life threatening or reoperation). The spinal x-rays showed no evidence of instability or spondylolysis. Her MRI revealed no evidence of nerve root compromise. There were no objective measures included in the documentation of changes in pain level or functional abilities with physical therapy. There was no evidence of failed trials of acupuncture or chiropractic therapy. There were no density test results. Given the lack of evidence as outlined above, there is insufficient information at this time to establish medical necessity for the requested procedure. Therefore, the request for L4-L5 decompression, transforminal lumbar interbody fusion is not medically necessary.

Assistant PA: 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.

Pre-operative; EKG, Labs, Medical Clearance: 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: 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.

DME BOA Classice Back Brace: 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.