MAXIMUS Federal Services

Case Number:	CM14-0201558		
Date Assigned:	12/11/2014	Date of Injury:	07/11/2012
Decision Date:	02/04/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/02/2014

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 Minnesota. 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 44-year-old male with a date of injury of 7/11/2012. The mechanism of injury is not reported. X-rays have revealed 3 level degenerative disc disease with loss of disc space height, particularly severe at L3-4 and L4-5 and to a lesser degree at L5-S1. MRI scan of the lumbar spine dated 5/14/2014 revealed multiple level degenerative disc disease and a mild scoliosis. There was 30% decrease in the height of the disc at L3-L4. There was a 2-3 mm posterior disc bulge with encroachment on the thecal sac but not on the foramina. No compromise of the traversing nerve roots nor the exiting nerve roots. At L4-5 there was 10% decrease in the height of the disc. There was a 3-4 mm left posterior lateral disc protrusion with encroachment on the left foramen and compromise of the nerve root. At L5-S1 there was 30% decrease in the height of the disc. The signal intensity was maintained. There was a 4-5 mm posterior disc bulge. There was no compromise of the traversing nerve roots. However, there was encroachment on the foramina with compromise of the exiting nerve roots bilaterally. Electromyography revealed possible chronic left L5 radiculopathy. No acute changes of denervation were noted in the paraspinal muscles. A Highly Complex Orthopedic Examination and Report dated 5/7/2014 concluded that the future care and treatment would consist of the use of oral analgesics as well as anti-inflammatories. The examiner did not find the patient to be a surgical candidate for his lower back. The provider has requested L3-5 posterior lumbar interbody fusion with instrumentation and possible addressing of junctional level pathology if present intraoperatively. According to the primary treating physicians reevaluation and progress report with request for surgical authorization dated 10/23/2014 the patient presented with continued low back pain radiating to the lower extremities. He had failed two epidural steroid injections and 12 physical therapy sessions. He had also attended 12 acupuncture sessions which offered him temporary relief. He was complaining of constant severe pain in the lower back

aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, prolonged standing, walking multiple blocks. The pain was sharp and stabbing. The pain level was 9/10. There was radiation into the lower extremities. In addition he complained of constant pain in the cervical spine. There was radiation into the upper extremities. The pain was 8/10. He also complained of frequent pain in both shoulders. The pain was 7/10. On examination his gait was normal. Range of motion was guarded and restricted. There was tingling and numbness in the anterolateral thigh, anterior knee, anterolateral and medial leg as well as foot in the L4 and L5 dermatomal pattern. There was 4/5 strength in the quadriceps and extensor hallucis longus. A request for L3-L5 posterior lumbar interbody fusion with instrumentation and possible addressing of junctional pathology intraoperatively was noncertified but utilization review using ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3 to L5 posterior lumbar interbody fusion (PLIF) with Instrumentation and possible addressing of junctional level pathology if present intra-operatively: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 10/28/14)

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

Decision rationale: California MTUS guidelines do not recommend spinal fusion in the absence of fracture, dislocation, complication of tumor, or infection. The guidelines indicate that patients with increased spinal instability after surgical decompression at the level of the degenerative spondylolisthesis may be candidates for fusion. Furthermore, there is no scientific evidence about the long-term effectiveness of the fusion procedure compared to the natural history and conservative treatment. The guidelines are not supportive of a spinal fusion in the absence of the above conditions and as such the request for a two-level fusion from L3-L5 with possible addressing of additional pathology at the junctional level is not supported by guidelines and as such, the medical necessity of the request is not substantiated.