

Case Number:	CM14-0202671		
Date Assigned:	12/15/2014	Date of Injury:	12/01/2005
Decision Date:	02/04/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	12/04/2014

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 Spine 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 63-year-old who reported injuries due to cumulative and repetitive trauma on 12/01/2005. On 10/21/2014, his diagnostic assessment included lumbar stenosis and depression. He complained of low back pain radiating to both legs, rated 6/10, with minimal improvement despite anti-inflammatories and physical therapy. He had 1 epidural injection which gave him 1 week's relief. Upon examination of the lumbar spine, there was tenderness to palpation over the paraspinal musculature. His ranges of motion were within normal limits. An MRI on 05/17/2013 revealed at L3-4, there was bilateral facet hypertrophy and mild to moderate acquired spinal stenosis; at L4-5, there was bilateral facet hypertrophy and a 2 mm disc narrowing, a 2 mm posterior central disc protrusion, bilateral foraminal narrowing, and moderate acquired spinal stenosis; at L5-S1, there was disc narrowing and bilateral foraminal narrowing. At the level of the S1 descending nerve roots, each contained a Tarlov cyst. The requested surgery was recommended due to his failed conservative treatment with anti-inflammatories, physical therapy and the temporary relief with the epidural injection, plus his neurological deficits that were concordant with the MRI findings. A Request for Authorization dated 10/28/2014 was included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-S1 decompression and fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307, 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic, Spinal Fusion.

Decision rationale: The request for L3-S1 decompression and 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 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 herniation that apparently does 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 electrophysiological evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and a 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 standardized 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. Except for cases of trauma related spinal fractures 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 on 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. The Official Disability Guidelines note that preoperative surgical indications for spinal fusion should include all of the following: (1) all pain generators are identified and treated, (2) all physical medicine and manual therapy interventions are completed; (3) x-rays demonstrating spinal instability and/or myelogram, CT myelogram, or discography, and MRI demonstrating disc pathology correlated with symptoms and exam findings; (4) spine pathology limited to 2 levels; and (5) psychological screening with confounding issues addressed. Physical therapy and anti-inflammatories were noted in this injured worker's medical records. There was no documentation of failed trials of antiepileptic

medications, chiropractic treatment, acupuncture, or muscle relaxants. Additionally, a Tarlov cyst was identified on his MRI, but not addressed in the clinical records. There were no x-rays demonstrating spinal instability. His MRI did not reveal any nerve root impingement. Additionally, there was no psychosocial assessment included in the submitted documentation. The clinical information submitted failed to meet the evidence based guidelines for the requested surgery. Therefore, this request for L3-S1 decompression and fusion is not medically necessary.