

Case Number:	CM14-0051192		
Date Assigned:	07/07/2014	Date of Injury:	05/08/2010
Decision Date:	05/05/2015	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	04/18/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 male, who sustained an industrial injury on May 8, 2010. The mechanism of injury is not indicated in the available records. The 12/8/13 lumbar spine MRI with contrast demonstrated findings status post laminectomy with attempted facet fusion from L2/3 through L5/S1. There were lateral disc-osteophytes at multiple levels, resulting in neuroforaminal stenosis. At L5/S1, there was mild impression upon the exiting right L5 nerve root within the foramen. There was no other significant impression upon the exiting nerve roots within their respective foramina. The 12/18/13 bilateral lower extremity electrodiagnostic study evidence bilateral L5 radiculopathies, characterized by no denervation and on-going re-innervation. The 2/3/14 CT scan impression documented spinal stenosis at the L4/5 and L5/S1 disc levels, laminectomy changes at the L4 and L5 vertebral bodies, and degenerative changes at the facet joints at L2/3, L3/4, L4/5, and L5/S1. There was spondylosis of the lumbar spine and degenerative disc disease at L4/5 and L5/S1 disc levels. An MRI with contrast was suggested to rule-out nerve root entrapment. The 3/7/14 treating physician report cited severe low back pain radiating down the leg. CT scan showed pseudoarthrosis at the L3/4 and L5/S1 level, at the other level the injured worker may be fused, but it was not certain. There was some bony bridging at the other levels. There was multilevel foraminal stenosis, as well as central stenosis at L4/5 and L5/S1. The treating physician stated that the injured worker had pseudoarthrosis and progressively worsening stenosis despite previous surgeries. A two-stage procedure was recommended, including an anterior spinal fusion with a Beck cage and standalone cages with screws at L5/S1, followed by a laminectomy and posterior spinal fusion and foraminotomy at

L4/5, L5/S1 and other levels that are tight. The 4/9/14 utilization review non-certified the request for lumbar spine surgery. The rationale for non-certification indicated that there was no history as to previous surgical procedures, attempts at conservative treatment, no physical exam and no evidence of pseudoarthrosis on the CT scan report to support the medical necessity of this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Staged-Anterior Spinal Fusion with Instrumentation at levels L3-4 and L5-S1: 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, Lumbar & Thoracic, Fusion (spinal).

Decision rationale: The California MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there is no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend revision surgery for failed previous operation(s) if significant functional gains are anticipated. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels and psychosocial screening with confounding issues addressed. Guideline criteria have not been fully met. The imaging records indicate that the patient has undergone lumbar surgery from L2/3 through L5/S1. Specific surgical history is not documented. The treating physician has reported findings of pseudoarthrosis at L3/4 and L5/S1, which is not documented in the CT scan report. There is no clinical exam provided to evidence nerve root compression. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. A psychosocial evaluation is not evidenced. Given the limited information available, the medical necessity of this request cannot be established. Therefore, this request is not medically necessary at this time.

Laminectomy Posterior Spinal Fusion with Instrumentation at levels L1-2, L2-3, L3-4, L4-5 and L5-S1: 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, Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The California MTUS guidelines recommend lumbar discectomy for carefully selected patients with nerve root compression due to lumbar disc prolapse. MTUS guidelines indicate that lumbar spinal fusion may be considered for patient with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there is no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar laminotomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Revision surgery is recommended for failed previous operation(s) if significant functional gains are anticipated. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been fully met. The imaging records indicate that the patient has undergone lumbar surgery from L2/3 through L5/S1. Specific surgical history is not documented. The treating physician has reported findings of pseudoarthrosis at L3/4 and L5/S1, which is not documented in the CT scan report. There is no clinical exam provided to evidence nerve root compression. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. A psychosocial evaluation is not evidenced. Given the limited information available, the medical necessity of this request cannot be established. Therefore, this request is not medically necessary at this time.

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.

7-Day 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic: Hospital length of stay (LOS).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Assistant Surgeon: 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.