

Case Number:	CM15-0100646		
Date Assigned:	06/03/2015	Date of Injury:	02/02/2000
Decision Date:	07/02/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	05/26/2015

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 61-year-old female who sustained an industrial injury on 2/2/00. The mechanism of injury was not documented. A significant flare was reported in August 2013 with conservative treatment including medications, physical therapy, lumbar bracing, activity/work modifications, and three epidural steroid injections. The 10/16/14 anatomic impairment measurements (AIM) report documented spondylolisthesis at L3/4 that was 1.32 mm in flexion and -0.69 in extension, L4/5 that was 6.9 mm in flexion and 6.6.1 mm in extension, and L5/S1 that was 0.4 mm in flexion and 2.08 mm in extension. The 4/23/15 treating physician report cited severe lower back pain radiating to both legs with weakness. She reported difficulty walking and falls. Physical exam documented 4/5 anterior tibialis and gastrocnemius weakness and 4+/5 iliopsoas and quadriceps weakness bilaterally. Straight leg raise was positive bilaterally. The injured worker was using a walker and had a limping antalgic gait. She had trouble rising from a seated position. The 10/24/14 lumbar MRI showed grade 2 spondylolisthesis of L4 on L5, and retrolisthesis of L5 over S1. There was disc desiccation at L3/4, L4/5, and L5/S1 with degenerative disc protrusions causing severe central canal stenosis at L4/5, moderate to severe central canal stenosis at L3/4. The L4/5 spondylolisthesis appeared to slightly increase in extension and slightly decrease in flexion. The diagnosis was lumbar intervertebral disc degeneration. Authorization was requested for 2 stage lumbar surgery including lumbar decompression laminectomy with reduction stabilization of the spondylolisthesis at L4/5 and L5/S1 with fixation and fusion followed by anterior lumbar discectomy and interbody fusion at L3/4, L4/5, and L5/S1 with iliac crest autograft. The 5/8/15 utilization review non-certified the request for anterior fusion as posterior decompression and fusion from L3-S1 had been certified and the medical necessity was not established relative to the grade 1 spondylolisthesis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Stage 2 Anterior Lumbar Discectomy and Interbody Fusion at L3-L4, L4-L5, L5-S1 with iliac crest autograft: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Fusion (spinal).

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 ½ Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The California MTUS guidelines recommend laminotomy, laminectomy, and discectomy for lumbosacral nerve root decompression. 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. 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. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Pre-operative clinical surgical indications generally 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 been met. This injured worker presents with severe low back and radiating lower extremity symptoms. Clinical exam findings are consistent with imaging evidence of moderate to severe central canal stenosis. There is radiographic evidence of spinal segmental instability at L4/5. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The treating physician opined the medical necessity of circumferential lumbar decompression and fusion. Review of the medical records indicate that adequate stability is not reasonable with only stage 1 surgery. Therefore, this request is medically necessary.

Associated Surgical Services: Facility Inpatient Stay, 3 days for Stage 2: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Fusion (spinal).

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 ½ Lumbar & Thoracic: Hospital length of stay (LOS).

Decision rationale: The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for anterior lumbar fusion is 3 days. Therefore, this request is medically necessary.

Associated Surgical Services: Post operative Cold Therapy Unit, unspecified duration:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Cold/heat packs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

Decision rationale: The California MTUS are silent regarding hot/cold therapy devices, but recommend at home applications of hot or cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for hot or cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of hot or cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a cold therapy unit in the absence of guideline support. Therefore, this request is not medically necessary.