MAXIMUS Federal Services

Case Number:	CM15-0107732		
Date Assigned:	06/12/2015	Date of Injury:	08/24/2013
Decision Date:	07/13/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	06/04/2015

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:

This injured worker is a 48-year-old female who sustained an industrial injury on 8/24/13. Injury occurred as a result of turbulence on the plane that caused her to lose balance and hit the right side of her back against the edge of a seat. Past medical history was positive for thyroid disease. Past surgical history was positive for two surgeries to the upper lumbar spine following a motor vehicle accident about 20 years ago. Records documented transforaminal epidural steroid injection right L5/S1 in 2014 with no significant benefit. She attended physical therapy in 2013 and 2014 without significant improvement. The 2/19/15 lumbar spine MRI impression documented distortion and abnormal anatomy of the distal most tip of the conus and cauda equina from the levels of L1 with a possibility of tethering and nerve root thickening and disorganization, findings that may reflect a chronic injury with possible intradural lesions. These findings were likely related to a traumatic event involving L2 with a fracture subluxation with retropulsion and mild canal stenosis at L1 and ligamentous injury given the abnormal signal and widening of the L1/2 interspinous distances. Correlation with CT scan was recommended. There was multilevel lumbar spondylosis. At L4/5, there was a disc bulge and ligamentum flavum hypertrophy with mild thecal sac compression and mild canal stenosis. There was mild left neuroforaminal narrowing abutting the exiting L4 nerve root. At L5/S1, there was diffuse disc bulge without significant canal stenosis and effacement of the thecal sac. There was mild bilateral neuroforaminal narrowing. The 2/23/15 lumbar spine x-rays with flexion and extension views documented an endplate deformity at L2 and spondylosis. There was no evidence of instability on flexion/extension. The 2/23/15 treating physician report cited constant low back

pain radiating down the posterolateral aspect of the right leg to the ankle and foot. Pain was aggravated by activity. Physical exam documented normal gait, 4+/5 right dorsiflexion and extensor hallucis longus weakness, and slightly diminished right lower extremity sensation diffusely. The injured worker had failed conservative treatment. The treatment plan included L4/5 decompression and fusion and obtaining a CT scan. The 3/12/15 CT scan documented a chronic burst fracture at L2, with mild posterior protrusion of the superior fracture fragments. There was facet arthropathy throughout, consistent with prior injury. Authorization was requested for L4-S1 decompression and instrumented fusion. The 5/6/15 utilization review non- certified the request for L4-S1 decompression and fusion as there was no imaging evidence of a significant neurocompressive lesion at L5/S1 to support surgery at that level, no evidence of a psychosocial screen, and no evidence of spinal instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 Decompression and instrumented fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

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 ï¿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. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar decompression 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. Fusion may be supported for surgically induced segmental instability. 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 met. This injured worker presents with constant low back pain radiating down the right lower extremity to the foot. Clinical exam findings are consistent with imaging evidence of nerve root compression at L4/5 and thecal sac effacement at L5/S1. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no radiographic evidence of spinal segmental instability or discussion of the need for wide decompression at both levels that would create temporary intraoperative instability necessitating fusion. Additionally, there is no evidence of a psychosocial screen. Therefore, this request is not medically necessary.