

Case Number:	CM15-0130812		
Date Assigned:	07/17/2015	Date of Injury:	12/22/2014
Decision Date:	08/14/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/07/2015

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 46-year-old male who sustained an industrial injury on 12/22/14, relative to cumulative trauma while working as a police officer/pilot. Conservative treatment included work restrictions, lumbar epidural steroid injection, physical therapy, home exercise program, and medications. The 12/30/14 lumbar spine X-rays demonstrated a marked decrease in L5/S1 disc space with moderate facet hypertrophy. The 1/7/15 lumbar spine MRI documented progression of degenerative disc and facet disease most notable at L5/S1. At L5/S1, there was a progression of disc height loss and eccentric disc osteophyte formation with interval development of an annular tear. There was progressive severe left and moderate right neuroforaminal narrowing. The 6/11/15 treating physician report cited constant severe low back pain radiating to the legs and feet, greater on the left. Back pain was worse than leg pain. Symptoms are aggravated with coughing, sneezing, prolonged standing and walking, sitting, driving, bending, twisting and turning. He had difficulty sleeping and woke with pain and discomfort. Physical therapy provided pain improvement but he remains symptomatic. Conservative treatment also included home exercise and traction. He was continuing to work full duty as a flight instructor. Physical exam documented normal gait, paravertebral muscle spasms and tenderness, sciatic notch tenderness, and painful range of motion. Straight leg raise testing was negative bilaterally. Lower extremity motor function was 5/5 and deep tendon reflexes were +2 and symmetrical. There was decreased left S1 dermatomal sensation. There was L5/S1 disc collapse with no instability noted on lumbar spine X-rays. The diagnosis was lumbar radiculopathy and lumbar disc collapse. The treatment plan recommended lumbar fusion

over decompression to address the back pain. Authorization was requested for L5/S1 transforaminal lumbar interbody fusion (TLIF), pre-operative medical clearance, and unknown post-operative medication. The 6/30/15 utilization review non-certified the L5/S1 TLIF and associated requests as there was no evidence of spinal instability on exam or X-rays, and no detailed documentation of conservative treatment having been exhausted.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) transforaminal lumbar interbody fusion at L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic), Fusion.

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 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 worsening low back pain radiating to the legs and feet. Clinical exam findings are consistent with imaging evidence of plausible nerve root compression at the L5/S1 level. 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. There is no discussion of the need for wide decompression that would result in temporary intraoperative instability necessitating fusion. Additionally, there is no evidence of psychosocial screening. Therefore, this request is not medically necessary.

Associated Service: One (1) 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

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

Unknown post-op medication: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Medications for acute pain (analgesics).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

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