

Case Number:	CM15-0131757		
Date Assigned:	07/20/2015	Date of Injury:	01/21/1994
Decision Date:	08/19/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/08/2015

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 57-year-old male who sustained an industrial injury on 1/21/94. The mechanism of injury was not documented. Conservative treatment included physical therapy, chiropractic, spinal injections, facet joint rhizotomies, activity modification, and medications. The 5/18/15 lumbar spine x-rays documented marked L5/S1 disc space narrowing, and moderate narrowing of the L1/2, L2/3, and L4/5 disc spaces. There was minimal multilevel spurring. There was no documentation of instability on flexion/extension views. The 5/15/15 lumbar spine MRI impression documented degenerative disc disease and facet arthropathy with L4/5 severe spinal stenosis, and L5/S1 moderate canal stenosis with narrowing of the left lateral recess with contact and displacement of the left S1 nerve root. There was severe left and moderate to severe right neuroforaminal narrowing at L4/5, and moderate to severe bilateral neuroforaminal narrowing at L5/S1. The 5/29/15 treating physician report cited symptoms had worsened since last seen on 5/4/15. He was using a cane for ambulation and had more difficulty commuting to work. The injured worker had exhausted extensive conservative treatment since 1994. Symptoms were consistent with neurogenic claudication. An orthopedic/neurologic exam was not documented. The diagnosis included left L5/S1 disc herniation, spinal stenosis severe at L4/5 and moderately severe central L5/S1, bilateral L4/5 and L5/S1 foraminal stenosis, bilateral lumbar radiculitis, L4/5 and L5/S1 intervertebral disc displacement and degenerative without myelopathy, chronic pain, generalized anxiety, and 40-year history of cigarette smoking. The treatment plan recommended a complex lumbar spine reconstructive procedure including L4/5 artificial disc replacement in combination with L5/S1 anterior interbody fusion with instrumentation. The injured worker was placed back on modified duty. Authorization was requested for L5/S1 anterior interbody fusion with instrumentation, L4/5 ADR (artificial disc replacement)/TDA (total disc arthroplasty), inpatient stay of 2-3 days, and pre-operative history and physical (including labs and EKG). The 6/24/15 utilization review non-certified the request

for L5/S1 anterior fusion with instrumentation and L4/5 ADR/TDA and associated surgical requests as there was no current orthopedic/neurologic exam, no psychosocial screening, no spinal instability, and imaging evidence of lumbar facet joint pathology and multilevel degenerative disease and fails to meet guideline criteria.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 anterior fusion with instrumentation: Upheld

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

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. 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 (ODG) recommends 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. The ODG state that lumbar spinal fusion is not recommended for workers compensation patients for degenerative disc disease, disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or non-specific low back pain. Pre-operative clinical surgical indications include all of the following: (1) All physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts including skilled therapy visits, and performance of home exercise program during and after formal therapy. (2) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or MRI demonstrating nerve root impingement correlated with symptoms and exam findings; (3) Spine fusion to be performed at one or two levels; (4) Psychosocial screen with confounding issues addressed; the evaluating mental health professional should document the presence and/or absence of identified psychological barriers that are known to preclude post-operative recovery; (5) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing; (6) There should be documentation that the surgeon has discussed potential alternatives, benefits and risks of fusion with the patient. Guideline criteria have not been met. This injured worker presents with a history of chronic lower back pain that has recently worsened with signs/symptoms of neurogenic claudication. Long term comprehensive conservative treatment and failure has been documented. There is no neurologic or orthopedic exam documented in the available records. Imaging demonstrated multilevel degenerative disc

disease and spinal stenosis with nerve root compression at the L5/S1 level. There is no radiographic evidence of spondylolisthesis or spinal segmental instability. There is documentation of potential psychological issues with no evidence that a psychosocial screening has been completed. There is documentation of a 40-year smoking history with no evidence of smoking cessation consistent with guidelines. Therefore, this request is not medically necessary.

L4-L5 ADR/TDA: Upheld

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

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, Disc prosthesis.

Decision rationale: The California MTUS guidelines do not provide recommendations for artificial disc replacement. Official Disability Guidelines state that artificial disc replacement is not recommended. The studies have failed to demonstrate superiority of disc replacement over lumbar fusion, which is also not a recommended treatment in ODG for degenerative disc disease. Furthermore, longevity of this procedure is unknown, especially in younger patients and the consequences of failure of an implant in close proximity to caudal equina and vital organs (e.g., aorta, vena cava and iliac arteries) are of concern. Current US treatment coverage recommendations were listed. Indications for lumbar ADR include primary back and/or leg pain in the absence of nerve root compression with single level disease. Patients exclusions also include spondylolisthesis, stenosis, facet mediated pain, and osteoporosis. FDA approved indications are listed as failure of 6 months non-operative treatment, skeletally mature patient, single disc only, no infection, no sensitivity to implant materials, and no osteoporosis or spondylosis. Guideline criteria have not been met. This injured worker presents with worsening back and leg symptoms. Clinical exam findings and imaging evidence are consistent with nerve root compression. There is imaging evidence of multilevel lumbar disc disease and stenosis. In addition, a disc replacement adjacent to a fused spinal segment would represent a hybrid-type complex/construct of which there are no significant long-term large volume medical literature studies at large. Therefore, this request is not medically necessary.

Associated Surgical Service: inpatient stay 2-3 days: 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 ½ 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.

Pre-operative history and physical (including labs and EKG): 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.