MAXIMUS Federal Services

Case Number:	CM15-0133907		
Date Assigned:	07/22/2015	Date of Injury:	07/09/2013
Decision Date:	08/21/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/10/2015

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 37-year-old male who sustained an industrial injury 7/09/13. Injury occurred while he was lifting, with immediate onset of low back pain. Conservative treatment had included medications, activity modification, and spinal injections. On 12/4/14, a provocative discogram was performed at L3/4 and L4/5 and reported negative without concordant pain. The 4/19/15 lumbar spine MRI findings documented a broad-based moderate central disc protrusion at L4/5 measuring 3.9 mm beyond the adjacent posterior vertebral body margins. There was effacement of the adjacent anterior thecal sac with the neural foramina appearing preserved. At L5/S1, there as a moderate broad-based central disc protrusion measuring 4.9 mm beyond the adjacent posterior vertebral body margins. There was narrowing of the recesses, slightly greater to the left and bilateral facet arthropathy with slight encroachment upon the neural foramina. The 5/29/15 treating physician report cited back and bilateral lower extremity pain, worse on the left. The left leg occasionally gave out on him. He was unable to work. Imaging demonstrated a large L5/S1 disc herniation with narrowing of the lateral recesses bilaterally, worse on the left. There was bilateral facet arthropathy at L4/5 with a large central disc herniation and foraminal narrowing. Physical exam documented moderate discomfort with palpation of the lumbar spine, painful and restricted lumbar extension, 4/5 left dorsiflexion and plantar flexion weakness, and diminished sensation over the lateral shin and anterior foot bilaterally. The diagnosis was lumbar stenosis with neurogenic claudication and lumbar disc displacement. The injured worker had failed all non-surgical therapies. He weighed 320 pounds and would not benefit from a microdiscectomy. He needed a bilateral L4/5 and L5/S1 total facetectomy and discectomy for

decompression of the nerve root. This will create iatrogenic instability and fusion at this level. Authorization was requested for transforaminal lumbar interbody fusion L4-S1 and a 3-day inpatient stay. The 6/23/15 utilization review non-certified the request for transforaminal lumbar interbody fusion at L4-S1 and associated inpatient stay as there was no clear imaging evidence of nerve root compression or central canal stenosis, no evidence of instability to support the medically necessary of a fusion, and no imaging evidence of a surgical lesion of such significance that a decompression alone would be insufficient.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Lumbar Interbody Fusion (L4-S1) sacroiliac: Upheld

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 - Decompressions.

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 recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. Guidelines indicate that lumbar spinal fusion may be considered for patient with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines (ODG) recommends criteria for lumbar discectomy 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 do not recommend lumbar fusion for patients with degenerative disc disease, disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or non-specific low back pain. Fusion may be supported for segmental instability (objectively demonstrable) including excessive motion, as in isthmic or degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. 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. Physical medicine and manual therapy interventions should include cognitive behavioral advice (e.g. ordinary activities are not harmful to the back, patients should remain active, etc.); (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) Smoking cessation 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 presented with persistent and function-limiting back and bilateral leg pain. Clinical exam findings are consistent with imaging evidence of plausible nerve root compression. The surgeon has documented the need for total facetectomy that would create temporary intraoperative instability necessitating fusion. However, there is no detailed documentation that this patient has completed all physical medicine and manual therapy interventions consistent with guidelines. There is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.

3 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 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.