MAXIMUS Federal Services

Case Number:	CM15-0134431		
Date Assigned:	07/22/2015	Date of Injury:	06/05/2012
Decision Date:	08/21/2015	UR Denial Date:	06/11/2015
Priority:	Standard	Application Received:	07/13/2015

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 35-year-old male who sustained an industrial injury on 6/05/12. Injury was reported relative to prolonged bending over while welding heavy gates. When he pulled up into a standing position, he felt a pop in his back. He underwent lumbar spine fusion at L2/3 and L3/4 on 10/9/12. The 5/4/15 bilateral knee x-rays showed isolated moderate lateral patellar osteophyte with no significant joint space narrowing. The 5/15/15 lumbar spine MRI impression documented posterior disc protrusion at L4/5 and L5/S1. At L4/5, there was a prominent central posterior disc protrusion, which measured approximately 6.6 mm beyond the adjacent posterior vertebral body margins. There was effacement of the adjacent anterior thecal sac with narrowing of the recesses and bilateral facet arthropathy with neuroforaminal narrowing. At L5/S1, there was mild to moderate broad-based central posterior disc protrusion, which measured approximately 4.5 mm beyond the adjacent posterior vertebral body margins. There was effacement of the adjacent anterior thecal sac with mild bilateral facet arthropathy. The 5/18/15 bilateral lower extremity EMG and nerve conduction study findings were compatible with a right peroneal nerve palsy at the level of the fibular head. The 6/3/15 treating physician report cited continued grade 8/10 lumbar pain. Physical exam documented restricted and painful range of motion with lumbar tenderness along the old scar. The treatment plan recommended continued Motrin, Ultram, and Flexeril. Authorization was requested for lumbar spine laminectomy and fusion at L4/5 and L5/S1. The 6/11/15 utilization review non-certified the request for lumbar laminectomy and fusion at L4/5 and L5/S1 as the electrodiagnostic evidence suggests peripheral neuropathy rather than left radiculopathy, radiculopathy was not reproduced with clinical testing,

and right knee pathology had not been fully ruled-out to support additional lumbar fusion in a young patient. The 7/27/15 agreed medical examiner (AME) report documented review of the 5/15/15 lumbar spine MRI. At L4/5, there was a moderate central right paracentral disc protrusion causing foraminal stenosis on the right, which was consistent with the injured worker's L4 radicular symptoms. The L4/5 disc derangement was causing moderate central stenosis with compromise of the lateral recess and likely right greater than left L5 nerve root compromise. At L5/S1, there was a slight disc bulge extending laterally, and in conjunction with facet hypertrophy, appeared to cause moderate foraminal stenosis bilaterally at L5/S1, which could further compromise the L5 nerve roots. The EMG findings of right peroneal neuropathy at the level of the fibular were suggestive of proximal denervation. The AME documented right calf atrophy, which was a likely manifestation of his radiculopathy. The injured worker had right L4 and L5 radicular symptoms with diminished sensation in the peroneal and/or L5 distribution in the lateral right calf and right calf atrophy. There was imaging evidence of prominent central, foraminal, and lateral recess stenosis at L4/5, which probably included compromise of the L4 and L5 nerve roots. There was relatively good correlation between symptoms, clinical findings, and diagnostic findings to support additional back surgery, including discectomy, decompression and fusion at L4/5. The AME was reluctant to recommend surgery at L5/S1 unless significant foraminal stenosis at L5/S1 was determined at the time of surgery and would benefit from decompression.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spine surgery, laminectomy and fusion of L4-L5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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 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) 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 persistent lumbar radicular pain consistent with an L4 and L5 radiculopathy. Clinical exam findings are consistent with plausible nerve root compression at the L4/5 level, and possibly at the L5/S1 level. Detailed 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 at both levels to support the medical necessity of 2-level lumbar fusion. Additionally, there is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.