

Case Number:	CM15-0135290		
Date Assigned:	07/23/2015	Date of Injury:	12/02/2013
Decision Date:	08/28/2015	UR Denial Date:	06/26/2015
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 36-year-old male who sustained an industrial injury on 12/2/13. He reported an onset of low back pain working on the food line when he lifting a 35-pound tray from a low shelf. Past medical and surgical history was negative. Social history was negative for smoking. Conservative treatment included physical therapy, acupuncture, home exercise program, anti-inflammatory drugs, muscle relaxants, lumbar support, and work modifications. The 9/13/14 electrodiagnostic study evidenced chronic L5 radiculopathy on the right. The 5/15/15 lumbar spine MRI impression documented findings much improved compared to 1/31/14. The large 13 mm eccentric to the right disc extrusion had decreased in size by about 60% and there was diminished mass effect on the right S1 nerve root and diminished encroachment on the right neural foramen. At L5/S1, there was moderate spondylosis with a 6 mm broad-based disc protrusion eccentric to the right neural foramen and an annular fissure. There was mild central canal stenosis, moderate to severe right and moderate left neuroforaminal stenosis, and mild bilateral facet joint degeneration and hypertrophy. The 5/28/15 treating physician report cited persistent significant low back pain ranging from 3-8/10 depending on activity. Pain was increased with activities of daily living and work activities. Physical exam documented guarded lumbar range of motion. The injured worker was neurologically intact in the lower extremities with negative bilateral straight leg raise. Imaging showed significant disc herniation at L5/S1 that was central with corresponding severe lateral recess stenosis. The injured worker had reportedly failed conservative treatment. Lumbar surgery was recommended to include decompression and instrumented fusion with interbody, and use of Infuse bone

morphogenetic protein. Authorization was requested for a lumbar fusion, preoperative clearance, and postoperative therapy for the lumbar spine. The 6/25/15 utilization review non-certified the lumbar fusion and associated surgical requests as there was no documentation of recent comprehensive conservative treatment failure, clinical findings of objective focal neurologic deficit, 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:

Lumbar 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 - Lumbar & Thoracic (online version).

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 state that there was 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. The guidelines recommend that clinicians consider referral for psychological screening 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) 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 presents with persistent and function-limiting low back pain. There is imaging evidence of improved findings of a residual L5/S1 disc protrusion with no documentation of current nerve root compression, although moderate to severe neuroforaminal stenosis is documented. Evidence of a long term reasonable and/or comprehensive non-operative treatment and failure has been submitted. However, clinical exam findings do not evidence nerve root compression. There is no radiographic evidence of spinal segmental instability. There is no discussion documented relative to the need for wide decompression that would result in temporary intraoperative spinal instability and necessitate fusion. Additionally, there is no documentation of a psychosocial screen. Therefore, this request is not medically necessary.

Preoperative clearance: 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.

Postoperative therapy x20 visits for the lumbar spine: 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.