MAXIMUS Federal Services

Case Number:	CM15-0140036		
Date Assigned:	07/29/2015	Date of Injury:	11/28/2014
Decision Date:	08/28/2015	UR Denial Date:	07/07/2015
Priority:	Standard	Application Received:	07/20/2015

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 49-year-old male who sustained an industrial injury on 11/28/14. Injury occurred while he was loading a 325-pound cast iron tub into a minivan. Conservative treatment included physical therapy, epidural steroid injection, selective nerve root block, medications, and activity modification. The 1/12/15 lumbar spine MRI impression documented multilevel lumbar spine spondylosis. At L4/5, there was a 5 mm posterior central disc herniation causing indentation and impingement on the anterior thecal sac, and elevation and stretching of the posterior longitudinal ligament. There was no significant central canal stenosis at this level. At L5/S1, there was a 3 mm posterior disc protrusion causing elevation and stretching of the posterior longitudinal ligament. There was an annular tear of the L5/S1 disc and 3 mm spondylolisthesis of L5 on S1. There was no significant thecal sac or lateral recess stenosis. Records indicated that the 4/16/15 lumbar spine x-rays with flexion/extension views did not documented instability. The 4/24/15 lumbar spine CT scan impression documented chronic bilateral spondylolysis at L5 with grade 1 anterolisthesis of L5 on S1. There was mild bilateral neuroforaminal at L3/4 due to disc bulge. There was mild to moderate left and mild right foraminal narrowing at L4/5 due to a mild to moderate disc bulge and mild facet arthropathy. There was mild bilateral foraminal narrowing at L5/S1 due to a mild disc bulge. Mild degenerative endplate changes were noted throughout the lumbar spine, most notably at L3/4. The 6/2/15 neurosurgical report cited worsening low back pain radiating into the lower extremities, left greater than right, in an L5 distribution. He was able to ambulate normally with no discernable weakness. Recent L4-L5 epidural steroid injections did not significantly alleviate

his symptoms. The 4/24/15 CT scan was reviewed and showed bilateral pars defects at L5 with foraminal stenosis at L5/S1. The neurosurgeon opined that the injured worker's low back pain was secondary to exaggerated mobility at L5/S1 from the bilateral pars defects compressing the L5 nerves. The treatment plan recommended a posterior lumbar decompression and fusion with instrumentation at L5/S1. Authorization was requested for a lumbar fusion and a post-operative lumbar back brace. The 7/2/15 utilization review non-certified the request for lumbar fusion and associated post-op back brace as there was no radiographic evidence of 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.

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. The California MTUS 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 criteria for lumbar decompression surgery 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 recommend lumbar spinal fusion as an option for patients with ongoing symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated e.g. acute traumatic unstable fracture, dislocation, spinal cord injury) for spondylolisthesis (isthmic or degenerative) with at least one of the following: instability, and/or symptomatic radiculopathy, and/or symptomatic spinal stenosis. Spinal instability criteria includes lumbar inter-segmental translational movement of more than 4.5 mm. 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 fully met. This injured worker presents with worsening low back pain radiating into the lower extremities consistent with L5 radiculopathy. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There was no comprehensive neurologic examination documented to correlate with imaging evidence of plausible L5 nerve root impingement. There was documentation of a 3 mm spondylolisthesis at L5/S1 with no radiographic evidence of instability. The treating physician noted pars defects on the CT scan which were not consistent with the radiologist's report. Additionally, there is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.

Postoperative lumbar brace: 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.