

Case Number:	CM15-0141320		
Date Assigned:	07/31/2015	Date of Injury:	11/04/2005
Decision Date:	09/17/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	07/21/2015

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 50-year-old male who sustained an industrial injury on 11/4/05. The mechanism of injury was not documented. Conservative treatment had included physical therapy, epidural steroid injection, medications and activity modification. Pain management reports indicated that he had been diagnosed with chronic reactive clinical depression. The 9/14/14 lumbar spine MRI conclusion documented congenitally short pedicles and epidural lipomatosis predisposing to acquired central canal stenosis. There were annular disc bulges contribution to moderate acquired central canal stenosis at L3/4 and L4/5. There was lower lumbar facet arthrosis and spondylosis contributing to multiple foraminal stenosis, most advanced at L5/S1. The 6/18/15 treating physician report cited continued moderate to severe, constant low back pain radiating down the anterior lateral thighs and occasionally into the lateral calves, left greater than right. Overall he described the pain as debilitating. He was unable to sit, stand, bend or twist without aggravation of pain. He had attempted to treat his symptoms with conservative care but as unable to tolerate increasing his level of activity. Walking caused increasing leg pain. Physical exam left quadriceps and dorsiflexion weakness. The recent MRI showed degenerative disc herniation at the L3-4 level causing central stenosis and neuroforaminal narrowing more on the left. The injured worker was a surgical candidate for anterior-posterior L3-4 lumbar decompression with interbody instrumented fusion. Authorization was requested for anterior/posterior L3/4 Lumbar decompression with interbody instrumented fusion, assistant surgeon, 3 days inpatient length of stay, and intraoperative spinal cord monitoring. The 6/26/15 utilization review non-certified the anterior/posterior L3/4 lumbar

decompression with interbody instrumented fusion and associated surgical requests as there was no evidence of instability on x-rays or spondylolisthesis noted to support the medical necessity of fusion. The 7/22/15 treating physician report appeal letter stated that the injured worker had severe and intractable low back pain radiating down the anterolateral left knee. He had undergone chiropractic care, acupuncture, epidural steroid injection, pain medications and activity modification. Despite conservative treatment, he had not been able to return to work or his previous level of activity. Overall, back pain was worse than leg pain. Leg pain was primarily on the left but intermittently on the right as well. Pain was grade 5-7/10. He was not able to sit, stand, bend, or twist without severe exacerbation of pain. He developed progressive symptoms with walking more than 20-30 minutes at a time. Imaging showed degenerative disc disease and acquired on congenital central canal stenosis. There was left greater than right lateral recess and foraminal stenosis along with hypertrophic facet changes. Surgery would most optimally include an L3/4 lumbar decompression with interbody and instrumented fusion. He would not likely respond to a simple decompression alone, as he had significant spinal stenosis and severe and intractable back pain. He did not have evidence of spondylolisthesis or ligamentous instability. This injured worker had significant degenerative disc disease, disc space height loss, and degenerative changes that would only be improved with reconstruction of the disc space by interbody cage placement and posterior decompression.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior/Posterior L3-L4 Lumbar decompression with interbody instrumented fusion:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Low Back, Lumbar and Thoracic, Criteria for Lumbar Spinal Fusion.

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 guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend 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 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. Spinal instability criteria includes lumbar inter- segmental translational movement of more than 4.5 mm. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability and/or imaging demonstrating nerve root impingement correlated with symptoms and exam findings, spine fusion to be performed at 1 or 2 levels, psychosocial screening with confounding issues addressed, and smoking cessation for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been met. This injured worker presents with severe and intractable low back pain radiating into the lower extremities, left worse than right. There was significant functional limitation documented precluding return to work. Clinical exam findings were consistent with imaging evidence of plausible nerve root compromise. 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. Imaging findings appear similar at the L3/4 and L4/5 levels, and most significant at the L5/S1 level. There is no discussion of the need for wide decompression that would result in temporary intraoperative instability necessitating fusion. Additionally, this injured worker has been diagnosed with chronic reactive clinical depression and a psychosocial screen is not evidence. Therefore, this request is not medically necessary at this time.

Associated Surgical Service: Assistant Surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Low Back, Lumbar and Thoracic, Criteria for Lumbar Spinal Fusion.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Service: 3 days length of stay as inpatient: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Low Back, Lumbar and Thoracic, Criteria for Lumbar Spinal Fusion.

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-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.

Associated Surgical Service: Intraoperative Spinal Cord Monitoring: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Low Back, Lumbar and Thoracic.

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-Lumbar & Thoracic: Intraoperative neurophysiologic monitoring (during surgery).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.