

Case Number:	CM15-0142769		
Date Assigned:	08/05/2015	Date of Injury:	09/17/2002
Decision Date:	09/24/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/23/2015

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 34-year-old male who sustained an industrial injury on 9/17/02. The mechanism of injury was not documented. He was status post lumbar laminectomy, posterolateral fusion and pedicle screw instrumentation at L4-S1 in 2009, and removal of screws for loosened instrumentation in 2012. Conservative treatment included medications and epidural steroid injection. Record documented the 3/7/13 lumbar spine MRI revealed multilevel degenerative disc disease resulting in mild left L3/4, mild bilateral L4/5, and moderate bilateral L5/S1 neuroforaminal narrowing. There was mild central canal narrowing at L3/4. The 3/7/13 lumbar spine x-rays showed post-operative changes at L4 and L5 with bony fusion across the facet joints and interval removal of screws. There was no acute fracture or subluxation. There was no significant anterior or posterior movement of the vertebral bodies on flexion and extension films. The 8/28/14 lumbar spine CT scan impression documented posterior laminectomy changes at L4/5 with evidence of previous posterior bilateral pedicle fusion of L4-S1 with interval removal of pedicle screws. There was multilevel degenerative disc change worst at L4/5, unchanged from previous imaging. At L3/4, the disc space was preserved and bilateral facet hypertrophy was noted. At L4/5, there was moderate disc space narrowing with a central posterior osteophyte, bilateral facet hypertrophy, and moderate right and mild left neuroforaminal narrowing. At L5/S1, there was bilateral facet hypertrophy and moderate neuroforaminal narrowing. The 6/1/15 neurosurgical report cited persistent back pain, intermittent leg pain, with numbness, tingling, and weakness. He was struggling to get about and his sleep quality was poor. At the time of the last surgery in 2012, there was evidence of

pseudoarthrosis at L5/S1. There was also evidence of probable pseudoarthrosis at L3/4. Physical exam documented normal gait and balance and good range of motion with no tenderness or spasms. Neurologic exam documented decreased L5 and S1 dermatomal sensation, trace patellar reflexes, absent Achilles reflexes, and severe right gastroc weakness. He had difficulty toe walking on the right. The diagnosis was chronic lower back pain with progressive exacerbation, probable pseudoarthrosis at L5/S1, lumbar spinal stenosis L3/4, history of prior fusion in situ L5/S1, and lumbar facet syndrome L3/4 and L5/S1. The injured worker had a positive history, exam and radiological studies. He was in need of anterior fusion at the L5/S1 level and posterior approach with instrumentation including iliac screws. He was not responding to conservative measures. Surgery would include lumbar laminectomy from L3-S1 with posterolateral fusion from L3 to S1 and anterior procedure as noted. Authorization was requested for L3-S1 laminectomy with posterolateral fusion from L3 to S1 and anterior procedure, pre-operative labs, pre-operative EKG, pre-operative chest x-ray, and a lumbar brace. The 6/29/15 utilization review non-certified the L3-S1 laminectomy with posterolateral fusion from L3 to S1 and anterior procedure and associated surgical requests as there was no imaging evidence of pseudoarthrosis or instability in the lumbar spine submitted for review, no current symptoms complaints or lower extremity deficits consistent with possible L5/S1 pathology, no clear surgical plan, and no documentation of attempts at conservative management.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-S1 laminectomy with posterolateral fusion and from L3-S1 and anterior procedure:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 recommend revision surgery for failed previous fusion at the same disc level if there are ongoing symptoms and functional limitations that have not responded to non-operative care; there is imaging confirmation of pseudoarthrosis and/or hardware breakage/malposition; and

significant functional gains are reasonably expected. Guideline criteria have not been met. This injured worker presents with persistent back pain with intermittent leg pain, numbness, tingling, and weakness. Clinical exam findings were consistent with imaging evidence of plausible nerve root compromise. However, detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no current imaging evidence of pseudoarthrosis at the previous surgical levels. There is no radiographic evidence of spinal segmental instability. There is no discussion or imaging evidence supporting the need for wide decompression to establish the medical necessity of extending the fusion to the L3/4 level. Additionally, there is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.

Preoperative Labs: 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.

Preoperative EKG: 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.

Preoperative Chest x-ray: 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.

Associated Surgical Service: 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.