

Case Number:	CM15-0144427		
Date Assigned:	08/05/2015	Date of Injury:	04/19/2013
Decision Date:	09/16/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	07/24/2015

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 47-year-old female who sustained an industrial injury on 4/19/13. Injury occurred while operating a jackhammer. Conservative treatment had included activity modification, physical therapy, epidural injections, facet rhizotomy and medications. The 5/1/15 lumbar spine MRI impression documented degenerative changes, most severe at the L4/5 level. At L4/5, there was mild disc height loss with a 2-3 mm diffuse disc bulge. The spinal canal was mildly stenotic. There was mild to moderate facet arthropathy and the disc bulge rendered mild to moderate right neuroforaminal stenosis. The 6/1/15 lumbar spine x-rays documented motion at the L4/5 with a resting 3 mm anterolisthesis of L4 on L5, increased to 7 mm on flexion. The 6/8/15 neurosurgical report cited severe lower back pain frequently radiating into the right buttock, posterolateral thigh, shin, and top and outside of the right foot, with frequent right leg tingling. Pain was constant and exacerbated by walking long distances, bending, or lifting. She had failed physical therapy, epidural injections, and radiofrequency rhizotomy. Physical exam documented normal lumbar range of motion, normal heel/toe walk, ability to squat and stand without assistance, 5/5 motor function, 2+ and symmetrical deep tendon reflexes, and absent clonus. Imaging showed a grade 1 spondylolisthesis at L4/5 with mild degenerative disc disease. At L4/5, there was also a broad-based disc protrusion with bilateral facet hypertrophy and posterior ligamentous thickening resulting in severe bilateral lateral recess stenosis and mild canal stenosis. There were also bilateral foraminal disc protrusions at L4/5, resulting in moderate to severe right and moderate left L4 foraminal stenosis. X-rays demonstrated instability at L4/5 with approximately 4 mm increased spondylolisthesis in flexion relative to extension. The injured worker had L4/5 unstable spondylolisthesis and marked bilateral lateral recess and foraminal stenosis. Authorization was requested for L4/5 transforaminal lumbar interbody fusion with

cage/screws, PA assistant, Inpatient surgery 3 day stay at community medical center, and Aspen lumbar brace to be fitted and given by our office for post-operative use. The 7/22/15 utilization review non-certified the L4/5 transforaminal lumbar interbody fusion and associated surgical requests as there was no documentation of smoking status, evidence of psychosocial screen, or review of all diagnostic testing, including the newly approved CT scan.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 Transforaminal lumbar interbody fusion, cage/screws qty 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

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 lower back pain radiating down the right leg to the foot with tingling in the same distribution. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Clinical exam findings documented a normal neurologic exam with no evidence of nerve root compression. Imaging findings were consistent with plausible nerve root compromise. There was evidence of a grade 1 spondylolisthesis with reported instability that did not meet guideline criteria of at least 4.5 mm of motion. There is no evidence of a psychosocial screen or documentation of smoking status for this patient. Therefore, this request is not medically necessary at this time.

Associated surgical service: PA assistant: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Surgical assistant.

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: Inpatient surgery 3 day stay at community medical center: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, length of stay (LOS).

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: Aspen lumbar brace to be fitted and given by our office for post operative use: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic: Lumbar supports.

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