

Case Number:	CM15-0144660		
Date Assigned:	08/05/2015	Date of Injury:	03/26/2015
Decision Date:	09/21/2015	UR Denial Date:	07/14/2015
Priority:	Standard	Application Received:	07/25/2015

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 3/26/15. Injury occurred while he was carrying an extension ladder at work. Conservative treatment included medications, physical therapy, and activity modification. The 4/10/15 lumbar spine MRI impression documented a disc extrusion at L4/5 in the right parasagittal/subarticular zone contributing to moderate to severe right and moderate left subarticular zone stenosis. There were chronic degenerative changes contributing to mild to moderate subarticular zone stenosis at L3/4. There was mild to moderate chronic degenerative neuroforaminal narrowing bilaterally at L3/4 and L4/5 and on the left at L5/S1 with a left far lateral/extraforaminal disc extrusion. There was annular fissuring at L2/3, L3/4, L4/5, and L5/S1 which could represent specific pain generators in the appropriate clinical setting. Findings documented a left far lateral/extraforaminal disc osteophyte complex/protrusion with 1.3 cm transverse based abutting the exiting left L5 ventral primary ramus. The 5/21/15 lumbar spine x-ray impression documented degenerative disc disease in the lumbar spine more pronounced at L4 through S1. There was arthritic facet joint disease at L4 and L5. There was no change in flexion and extension views. The 5/26/15 electrodiagnostic study documented electrical evidence of left L5 radiculopathy. The 7/3/15 treating physician report cited continued low back pain radiating down the left lower extremity. Rotating and twisting caused shooting pains down the left lower extremity. He had weakness and floppiness of his left foot. He had difficulty sleeping at night and was feeling distraught. Physical therapy seemed to make his pain worse. Lumbar spine exam documented mild paraspinal atrophy, left paraspinal tenderness, limited range of motion, and positive left straight leg.

Neurologic exam documented 4/5 left quadriceps, tibialis anterior, and extensor hallucis longus weakness and decreased L5 dermatomal sensation on the left. The diagnosis included left L4/5 and L5/S1 disc extrusions with associated weakness in the tibialis anterior and extensor hallucis longus, and L4/5 and L5/S1 facet arthrosis and degenerative facet arthropathy contributing to impinging lesions on the left L5 nerve root. The treating physician report recommended surgery to treat the large herniated disc with associated facet arthrosis and foraminal stenosis. Authorization was requested for lumbar decompression and fusion, post-op brace, post-op physical therapy 12 sessions, pre-op EKG, and pre-op chest x-ray. The 7/14/15 utilization review non-certified the lumbar decompression and fusion and associated surgical requests as there was no evidence of instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar decompression and 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 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 persistent and function-limiting low back pain radiating down the left lower extremity. Clinical exam findings are consistent with imaging evidence of plausible multilevel nerve root compression. 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 on flexion/extension films. There is no discussion of the need for wide decompression that would create temporary intraoperative instability and necessitate fusion. There is no evidence of a psychosocial screen. Additionally, this request lacks specificity required to fully establish medical necessity. Therefore, this request is not medically necessary.

Post op brace: 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): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138-139.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Post op physical therapy, 12 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Pre op EKG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Pre op chest xray: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.