

Case Number:	CM15-0145116		
Date Assigned:	08/06/2015	Date of Injury:	02/02/1991
Decision Date:	09/09/2015	UR Denial Date:	07/16/2015
Priority:	Standard	Application Received:	07/27/2015

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 72-year-old male who sustained an industrial injury on 2/2/91. The mechanism of injury was not documented. Past medical history was positive for morbid obesity (BMI 80.85), diabetes, and hypertension. He underwent decompressive laminectomy, posterior lumbar interbody fusion and lateral mass fusion at L4/5 and L5/S1 with pedicle screw fixation at bilateral L4-S1 on 5/23/12. Conservative treatment had included medications, chiropractic, physical therapy, psychotherapy, epidural steroid injections, medial branch blocks, and activity modification. The 8/22/14 lumbar spine MRI impression documented canal, lateral recess, and foraminal narrowing at the L3/4 with nerve root abutment but no definite impingement. There was left posterior disc osteophytic ridging at L4/5 abutting the descending nerve roots within the left lateral recess and minimally along the undersurface of the exiting nerve root from the left L4/5 foramen but no definite impingement was appreciated at this level. At L5/S1, there was a partially extruded interbody fusion device encroaching the left lateral recess and contributing to left neuroforaminal narrowing. There was abutment and posterior displacement of the descending nerve roots within the left lateral recess. Posterolateral and far lateral disc osteophytic ridging at L5/S1 also abutted and imprinted the exiting nerve root from the right neural foramen. The 5/18/15 treating physician deposition documented review of April 2014 x-rays with findings of a 5 mm anterolisthesis at L3 on L4. The 6/1/15 treating physician notes documented review of the MRI and plain films. Imaging showed intact and stable fusions and hardware from L4 to S1, with the exception of stenosis of the left S1 foramen. There was moderate to marked stenosis at the L3/4 with an anterolisthesis of L3 on L4. The surgical plan

was to address the L3/4 level with a decompressive laminectomy and instrumented fusion, which would involve connecting to the inferior hardware and likely necessitate posterior instrumentation removal to connect to 2 pedicle screws at the L3 level. The S1 stenosis would not be addressed in this surgery. Psychiatric progress reports from 1/15/15 to 6/4/15 documented on-going depression and anxiety secondary to pain, which was becoming progressively worse. It was noted that surgery had been recommended by the neurosurgeon. The 6/23/15 treating physician report cited increasing severe low back pain radiating down the legs with numbness and tingling. Pain was worse with weight bearing, prolonged sitting, and standing. Pain was associated with increased foot drop, numbness and tingling, and bladder issues. Pain was generally relieved with Percocet. The injured worker was considering a gastric bypass. Physical exam documented marked decreased lumbar range of motion with forward flexed posture. Surgical authorization was still pending. Authorization was requested for laminectomy and instrumented fusion connecting to existing hardware with possible removal of posterior instrumentation L3/4, and a 2-night inpatient hospital stay. The 7/16/15 utilization review non-certified the request for laminectomy and fusion at L3/4 and associated inpatient stay. There was no current evidence of a sensorimotor deficit or positive root tension sign, radiographic evidence of instability, evidence that other causes of pain had been ruled-out such as infection or nonunion, or documentation of pre-surgical psychological clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Laminectomy and instrumental fusion connecting to existing hardware with possible removal of posterior instrumentation L3-L4: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), chapter: low back.

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 in 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 recommend lumbar spine fusion as an option for patients with degenerative spondylolisthesis with instability and/or symptomatic radiculopathy, and/or symptomatic spinal stenosis when there are corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated e.g. acute traumatic unstable fracture, dislocation, spinal cord injury) subject to

pre-surgical clinical indications. 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. (2) X-rays demonstrating spinal instability and/or imaging 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 been met. This injured worker presents with progressively worsening and severe low back pain radiating into the lower extremity with numbness and tingling. His foot drop was reported as worsening. There is imaging evidence of 5 mm anterolisthesis at L3 on L4 with findings consistent with nerve root compromise. Detailed evidence of long-term reasonable and/or comprehensive non-operative treatment and failure has been submitted. There are psychological issues present due to chronic pain with regular psychiatric treatment documented, and, no evidence that additional fusion surgery is not supported. Therefore, this request is medically necessary.

Associated surgical services: In-patient hospital stay, 2 nights: Overturned

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

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: The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for anterior, lateral, or posterior lumbar fusion is 3 days. A 2-night length of stay is within guideline recommendations. Therefore, this request is medically necessary.