

Case Number:	CM15-0145367		
Date Assigned:	08/07/2015	Date of Injury:	09/09/2009
Decision Date:	09/23/2015	UR Denial Date:	06/23/2015
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:

The injured worker is a 36-year-old male who sustained an industrial injury on 9/9/09. Injury occurred when he and his coworkers were lifting a metal ramp, and he felt some pull in his low back with gradual increase in pain. He underwent L4/5 microdiscectomy in 2010. The 1/17/14 lumbar spine x-rays documented degenerative disc disease at L3/4, L4/5, and L5/S1. The 7/18/14 lumbar spine MRI impression documented a 4 mm broad-based central disc protrusion with an annular fissure at L2/3 with moderate central canal stenosis and bilateral facet hypertrophy. At L3/4, there was a 4 mm circumferential disc bulge with moderate bilateral neuroforaminal narrowing, moderate central canal stenosis, and bilateral facet hypertrophy. At L4/5, there was a 4 to 5 mm broad-based central to right foraminal zone disc protrusion most prominent in the right subarticular zone with an annular fissure. There was impingement of the right transiting nerve roots. There was moderate to severe right and mild left neuroforaminal narrowing. There was mild central canal stenosis and bilateral facet hypertrophy with ligamentum flavum redundancy. At L5/S1, there was a right hemilaminotomy with mild reactive marrow edema along the superior endplate of the L5 vertebral body extending into the right pedicle. The 8/19/14 EMG/NCV study was reported unremarkable. The 1/23/15 psychological evaluation report indicated that injured worker was suitable to undergo a spinal fusion. Conservative treatment had included physical therapy, chiropractic care, acupuncture, epidural steroid injection, and medication management. The 6/15/15 treating physician report cited grade 7/10 low back pain radiating down the right leg to the toes. He reported pain associated with weakness and numbness in his legs, giving way in the right leg, and locking and swelling of the low back and right leg. Symptoms are aggravated with overhead reaching, pushing, pulling,

gripping, twisting, bending, stooping, kneeling, and sitting. He was taking medications and doing stretching exercises at home. He had less radicular symptoms and was taking less medications. Lumbar spine exam documented tenderness and spasms, and positive straight leg raise on the right greater. The diagnosis was lumbar spine disc protrusion with stenosis, lumbar degenerative disc disease and status post L4/5 microdiscectomy in 2010. Authorization was requested for anterior/posterior lumbar discectomy, decompression and fusion with instrumentation, allograft and bone morphogenetic protein (BMP) at L4/5, pre-operative medical clearance, 1 day inpatient stay, 12 post-operative physical therapy visits, post-operative cold therapy, and postoperative bone stimulator. The 6/23/15 utilization review non-certified the anterior/posterior lumbar discectomy, decompression and fusion with instrumentation, allograft and BMP at L4/5 and associated surgical requests as there was no radiographic evidence of instability or reasonable expectation of post decompression iatrogenic instability, and the clinical evaluation did not correlate with imaging studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior/posterior lumbar discectomy, decompression and fusion with instrumentation, allograft and morphenetic protein at L4-5: Upheld

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

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 low back pain radiating down the right leg to the toes. Pain was reportedly associated with numbness, tingling and weakness. Clinical exam findings were consistent with imaging evidence of nerve root impingement at L4/5. Evidence of long-term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Psychological clearance for fusion surgery is noted. However, there is no radiographic evidence of spinal segmental instability. There is no discussion of the need for wide decompression that would create temporary intraoperative instability necessitating the need for fusion. Therefore, this request is not medically necessary.

Associated surgical services: Pre-operative medical clearance: 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 services: 1 day inpatient stay: 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 services: Post-operative physical therapy 3 x 4 weeks: 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 services: Post-operative cold therapy: 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 services: Post-operative bone stimulator: 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.