

Case Number:	CM15-0146353		
Date Assigned:	08/07/2015	Date of Injury:	09/30/2014
Decision Date:	09/17/2015	UR Denial Date:	07/23/2015
Priority:	Standard	Application Received:	07/28/2015

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 48-year-old male who sustained an industrial injury on 9/30/14. Injury occurred when he tripped and fell while carrying a 10-foot Corian counter, causing the counter to fall on top of him. Conservative treatment included tend, physical therapy, activity modification, and medications. The 10/20/14 lumbar spine x-ray findings documented normal alignment, severely narrowed disc at L4/5, scattered marginal osteophytes, and hypertrophic facet joints at L4-S1. The 12/5/14 lumbar spine MRI impression documented no evidence of fracture/dislocation, marrow replacing process, or intraspinal/paraspinal mass. There was facet joint degenerative joint disease at L5/S1. At L4/5, there was disc degeneration with broad disc protrusion, ligamentous thickening, and facet joint overgrowth with right greater than left neuroforaminal narrowing. There was mild to moderate disc protrusion eccentric to the left neuroforamen at L3/4. There was moderate disc degeneration and mild to moderate disc protrusion at L1/2. The 12/19/14 electrodiagnostic study findings were reported most consistent with left S1 radiculopathy. The 6/24/15 spine surgery report cited grade 4-6/10 low back pain radiating down the back of the left leg to the calf. He complained of urinary urgency and frequency. Pain was worse with sitting, standing or walking more than 15-20 minutes. Conservative treatment included NSAIDs, 16 sessions of physical therapy, and activity modification. Review of systems documented a history of depression, nervousness and mood change. Lumbar spine exam documented compensated gait, tenderness to palpation, normal paraspinal muscle tone, restricted and painful range of motion, and negative straight leg raise. Motor and reflex testing was within normal limits. Lumbar x-rays showed a collapse

degenerative dis at L4/5. The injured worker had significant symptom-producing lumbar disease at L4/5. There was significant spinal stenosis and a collapsed disc with axial back pain and radicular symptoms primarily into the left lower extremity. He had positive EMG findings. Authorization was requested for left L4/5 lateral interbody cage fusion with posterior spinal fusion/instrumentation and laminectomy L4/5, pre-operative visit, assistant surgeon, and 3 day inpatient stay. The 7/23/15 utilization review non-certified the left L4/5 lateral interbody cage fusion with posterior spinal fusion/instrumentation and laminectomy L4/5 and associated surgical requests as there was no documentation of spinal instability or evidence of a psychiatric evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 Lateral Interbody case fusion (left) with PSF/Instrumentation and Laminectomy

L4- 5: 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 function-limiting low back pain radiating down the back of the left leg to the calf. He complained of urinary frequency and urgency. There are no current clinical exam findings of sensory, motor or reflex changes that correlate with imaging or electrodiagnostic evidence of plausible nerve root compression. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is no radiographic evidence of spinal segmental instability. There is no discussion of the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. There is documentation of psychological symptoms with no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.

Associated surgical service: Assistant Surgeon: 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 stay 3 days: 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, Hospital 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.

Pre-operative visit: 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 Office Visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 edition, pages 92-93.

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

