

Case Number:	CM15-0161529		
Date Assigned:	08/27/2015	Date of Injury:	06/28/1999
Decision Date:	09/30/2015	UR Denial Date:	07/23/2015
Priority:	Standard	Application Received:	08/17/2015

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 49-year-old male who sustained an industrial injury on 6/28/99. Injury was reported relative to a faulty tow truck transmission requiring that he hold the gearshift level manually into gear. He underwent right shoulder surgery. The 10/8/13 lumbar spine MRI findings documented an L5/S1 moderate broad-based posterior disc protrusion measuring 5.0 mm beyond the adjacent posterior vertebral body margins with effacement of the adjacent thecal sac with narrowing of the recesses bilaterally. There was narrowing of the recesses at L4/5. Conservative treatment included medications, physical therapy, activity modification and pain management. Intervention pain management included L5/S1 epidural injections, bilateral sacroiliac joint injections one 8/2/13, and bilateral lumbar facet blocks, all with no relief. The 7/9/15 treating physician report cited 9/10 low back pain radiating to the left lower extremity. The injured worker reported worsening knee pain with popping due to increased kneeling and squatting to avoid back flexion. Physical exam documented lumbar hypertonicity, tenderness at L4-S1 bilaterally, bilateral sciatic notch tenderness, and tenderness in the posterior aspects of both thighs along the course of the sciatic nerves. Lumbar range of motion was painful and markedly restricted. Bilateral knee range of motion was full and symmetrical. He was able to toe-walk, heel-walk and ambulate without difficulty. Sensation was intact over the lower extremities. The injured worker had prominent degenerative disc disease at L5/S1 consistent with physical exam and subjective complaints. His level of activities of daily living were reflective of a moderately severe impairment. Authorization was requested for L5/S1 decompression and fusion per the neurosurgeon. The 7/23/15 utilization review non-certified the

request for L5/S1 decompression and fusion as there was no documentation of severe disabling lower extremity symptoms in a distribution consistent with abnormalities on imaging studies, activity limitation due to radiating leg pain, or failure of conservative treatment to resolve lower extremity symptoms. The 8/6/15 physical therapy cited continued worsening lower back pain radiating to the buttocks and left lower extremity with limited activities of daily living. Physical exam was unchanged. The injured worker remained in need of surgery per the neurosurgeon. There was no neurosurgical report in the provided records.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Decompression and fusion at L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288.

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 into the bilateral buttocks and left lower extremity. Moderately severe functional limitation is reported in activities of daily living. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment

protocol trial and failure has been submitted. There is imaging evidence of plausible nerve root compression at L5/S1. However, there are no clinical exam findings of neural compression documented in the records provided. There is no radiographic evidence of spondylolisthesis or spinal segmental instability on flexion and extension x-rays. There is no discussion or imaging evidence supporting the need for wide decompression that would result in temporary intra-operative instability and necessitate fusion. There is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.