

Case Number:	CM15-0161961		
Date Assigned:	08/27/2015	Date of Injury:	03/25/2013
Decision Date:	09/30/2015	UR Denial Date:	07/21/2015
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 44-year-old male who sustained an industrial injury on 3/25/13, relative to repetitive lifting and bending. Conservative treatment included epidural steroid injection, physical therapy, activity modification, and medication. He underwent left L4/5 lumbar decompression surgery on 8/13/14 with initial benefit reported for a few months, followed by an onset of progressive back and left leg pain. The 1/20/15 lumbar spine MRI impression documented prior left L4/5 hemilaminotomy for presumed prior microdiscectomy surgery. There was a residual or recurrent 5 mm broad posterior disc protrusion at L4/5 and mild facet arthropathy resulting in mild to moderate spinal stenosis and moderate bilateral neuroforaminal narrowing. There was a 2-3 mm broad posterior disc protrusion at L5/S1 with mild to moderate facet arthropathy resulting in mild bilateral neuroforaminal narrowing. There was a 2-3 mm broad disc posterior disc protrusion at L3/4 indenting the anterior thecal sac with no significant spinal stenosis. There was clumping of the cauda equina at the L4/5 level without abnormal enhancement and with normal appearance of the cauda equina proximally, likely relative to spinal stenosis. There was mild to moderate L5/S1 and mild L4/5 bilateral facet arthropathy. The 2/18/15 lumbar spine CT scan impression documented a 5 mm broad posterior disc protrusion versus postsurgical epidural scarring with at least moderate spinal stenosis and moderate bilateral neuroforaminal narrowing. There was a 3 mm broad posterior disc protrusion at L3/4 with questionable spinal stenosis and neuroforaminal narrowing. The 3/10/15 spine surgery consult report cited progressive back and left leg pain that was quite severe. He had failed conservative treatment. Physical exam documented 4/5 left extensor hallucis longus and anterior tibialis

weakness, positive straight leg raise, pain with lumbar extension, and an antalgic gait. Lumbar x-rays were obtained and showed a slight spondylolisthesis at L4/5 with narrowing and collapse of the L4/5 disc space. Imaging showed significant lateral recess and foraminal stenosis due to the disc space collapse. There was slight instability on the flexion/extension films and he had undergone a previous decompression. Surgery was recommended to include L4/5 anterior lumbar interbody fusion followed by posterior decompression on the left and fusion with instrumentation at L4/5. The 7/7/15 treating physician report cited constant low back pain radiating to the lower extremities. Pain was increased with bending or prolonging standing/walking. Review of systems was positive for stress and anxiety. Lumbar spine exam revealed tenderness to palpation over the lumbosacral midline, left buttocks and left sciatic notch. There was pain with lumbar flexion and extension, and bilateral hamstring tightness. MRI findings from 7/15/14 were documented. The diagnosis included status post lumbar surgery 8/13/14 with possible sleep disorder, stress, and depression. The injured worker had recurrent leg pain due to disc space collapse and foraminal stenosis due to up and down stenosis. Surgery was recommended per spine consult. Authorization was requested for L4/5 anterior interbody fusion with instrumentation and left sided posterior decompression. The 7/21/15 utilization review non-certified the request for L4/5 decompression and fusion as there was no evidence of segmental instability, no indication of flexion and extension movements on plain films, and no evidence of post-operative imaging demonstrating on-going compressive pathology.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 Anterior interbody fusion with instrumentation and left side posterior decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

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 electrophysiological evidence of a lesion that has been shown to benefit in both 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, with relative angular motion greater than 15 degrees L1-2 through L3-4, 20 degrees L4-5, 25 degrees L5-S1. 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 recurrent low back pain radiating to tin left lower extremity with numbness and tingling to the foot. He underwent L4/5 decompression in August 2014 with initial benefit followed by recurrence of symptoms. Clinical exam findings are consistent with imaging evidence of a recurrent disc protrusion at L4/5 with plausible nerve root compromise. 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 and extension x-rays. There is a reported slight spondylolisthesis at L4/5 with "slight" instability noted on the flexion/extension films but no documentation of the level of inter-segmental translational movement. There is no discussion supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. Potential psychological issues are documented with no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.