

Case Number:	CM15-0163962		
Date Assigned:	09/01/2015	Date of Injury:	02/02/2015
Decision Date:	10/09/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/20/2015

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 50-year-old male who sustained an industrial injury on 2/02/15. Injury occurred when he was lifting cases of milk off the side door of a truck box and setting them on the sidewalk. He reported that his lower back popped twice with onset of extreme pain into the buttocks. The 2/6/15 lumbar spine MRI impression documented normal alignment, and narrowing of the L3/4, L4/5, and L5/S1 disc spaces. At L3/4, there was a broad-based disc bulge with facet and ligamentum hypertrophy resulting in moderate central stenosis with significant foraminal encroachment. At L4/5, there was a broad-based disc bulge with facet and ligamentum hypertrophy resulting in severe central stenosis and narrowing of the right neural foramen. At L5/S1, there was a broad-based disc bulge resulting in narrowing of the left lateral recess and left foraminal encroachment. The 7/17/15 treating physician report cited low back pain radiating into the right buttock, thigh and leg with numbness and tingling involving the anterior thigh and leg, and weakness involving the leg, ankle and foot. He had failed conservative treatment including activity modification, medications, extensive physical therapy, epidural steroid injection, and oral steroids. Physical exam documented a mild right-sided limp, guarded thoracolumbar range of motion, decreased sensation over the anterior right thigh and diffusely in the right leg, and 4/5 right ankle dorsiflexion. X-rays were taken and showed mild to moderate segmental scoliosis with asymmetric disc space collapse on the right. At L5/S1, there was a vacuum disc with severe disc space narrowing. At L3/4, there was mild disc space narrowing. Imaging showed a broad-based disc bulge, facet joint degeneration and thickened ligamentum with severe central canal stenosis at L4/5 with severe right-sided neuroforaminal stenosis with frank compression of the

L4 nerve root. The injured worker continued to have severe low back pain and neurogenic claudication involving the right lower extremity with a combination of L4 and L5 nerve root symptoms with radiating pain, loss of sensation and weakness, including partial right foot drop. Authorization was requested for L4/5 lumbar interbody fusion and posterior spinal fusion, and 3-day inpatient stay. The 7/31/15 utilization review non-certified the L4/5 lumbar interbody fusion and posterior spinal fusion and 3-day inpatient stay as there was no evidence of significant motion segment instability, severe degenerative disc space collapse, or psychosocial assessment.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 Lumbar interbody fusion and posterior spinal fusion: 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, 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 severe low back pain radiating into the right lower extremity with numbness, tingling and weakness. Signs/symptoms and clinical exam findings are

consistent with imaging evidence of nerve root compression at the L4/5 level. Detailed 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 spondylolisthesis or spinal segmental instability documented on flexion and extension X-rays consistent with guideline criteria. There is no discussion supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. There is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.

Associated surgical service: 3 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.