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| Case Number: | CM15-0166433 | | |
| Date Assigned: | 09/04/2015 | Date of Injury: | 06/01/1997 |
| Decision Date: | 10/19/2015 | UR Denial Date: | 08/11/2015 |
| Priority: | Standard | Application Received: | 08/25/2015 |

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 69-year-old male who sustained an industrial injury on 6/1/97. The mechanism of injury was not documented. Past surgical history was positive for diabetes, chronic obstructive pulmonary disease, coronary artery disease, hypertension, anxiety, benign adrenal mass, benign central nervous system mass, and questionable posttraumatic stress disorder. Past surgical history was positive for thoracotomy for lung cancer, followed by radiation therapy. He underwent anterior cervical discectomy and fusion C3-C7 with plate fixation on 2/9/15. The 7/1/15 lumbar spine x-ray findings documented minimal degenerative anterior subluxation at the L2/3, which was stable on flexion and extension. There were no other subluxations seen. There was degenerative disc disease at L2/3, L3/4, and L4/5 with minimal spurring. The 7/1/15 treating physician report indicated that the injured worker likely required a laminectomy for decompression of L2/3, L3/4, and L4/5, but a fusion was not required as there was no evidence of deformity. The 7/16/15 lumbar spine MRI impression documented multilevel degenerative spondylosis. At L4/5, there was moderate central canal stenosis combined with osteoarticular degenerative overgrowth posteriorly with left paracentral compressive posterior lateral disc extrusion with entrapment of the traversing left L5 nerve root. At L3/4, there was hypertrophic facet arthropathy, discal dehydration, and subarticular far lateral discal extrusion compressing the exiting right L3 nerve root with mild central canal stenosis. There was severe central canal stenosis at L2/3 with hypertrophic facet arthropathy, midline discal compressive extrusion with severe compressive changes of thecal sac and contents without lateralization. The 7/22/15 treating physician report cited low back pain radiating into the bilateral lower extremities with claudication type symptoms. He could not walk more than a few feet.

Physical exam documented shuffling gait, positive Hoffmann sign, and left lower extremity weakness in left foot and toe dorsiflexion, and left hip flexors and extensors. Conservative treatment had included lumbar epidural steroid injection, physical therapy, and medication management. Authorization was requested for lumbar decompression and instrumented fusion with transforaminal lumbar interbody fusion at L2/3, L3/4, and L4/5 with allografts and an inpatient hospital stay. The 8/10/15 utilization review modified the request for lumbar decompression and instrumented fusion with transforaminal lumbar interbody fusion at L2/3, L3/4, and L4/5 with allografts with inpatient stay to lumbar decompression of L2/3, L3/4, and L4/5 with a 2-day inpatient hospital stay. Records indicated that the injured worker subsequently underwent lumbar decompression surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Decompression and Instrumented Fusion with Transforaminal Lumbar Interbody Fusion L2-L3, L3-L4, and L4-L5 with Allografts: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Fusion (spinal).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. 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 and function-limiting low back pain radiating into the bilateral lower extremities with claudication type symptoms. Clinical exam findings are consistent with imaging evidence of spinal stenosis at the L3/4 through L5/S1 levels with nerve root compromise. Evidence of long-term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no radiographic evidence of significant 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 intraoperative instability and necessitate fusion. The 8/10/15 utilization review partially certified this request for lumbar decompression of L2/3, L3/4, and L4/5. There was no compelling rationale presented to support the medical necessity of additional surgical certification. Records indicated that the injured worker subsequently underwent the decompression procedure. Therefore, this request is not medically necessary.

Associated surgical service: Inpatient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Length of Stay.

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: The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median length of stay for lumbar laminectomy is 2 days and best practice target is 1 day. The 8/10/15 utilization review modified the request for non-specific inpatient hospital stay to 2-day inpatient stay consistent with lumbar decompression surgery. There is no compelling rationale to support the medical necessity of additional length of stay. Therefore, this request is not medically necessary.