

Case Number:	CM15-0193620		
Date Assigned:	10/07/2015	Date of Injury:	02/11/2011
Decision Date:	11/16/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	10/01/2015

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 45-year-old male who sustained an industrial injury on 2/11/11. Injury occurred when he was lifting a propane tank and felt a popping sensation in his low back. He was diagnosed with L5/S1 degenerative disc disease and left sided S1 radiculopathy and underwent a left L5-S1 partial laminotomy, partial medial facetectomy and microdiscectomy on 7/2/13. He reported resolution of his leg symptoms with surgery and was able to return to work. The treating physician progress reports documented increasing symptoms over time. Records documented the 12/3/14 lumbar spine MRI showed post-surgical changes of left L5/S1 semi-hemilaminectomy and microdiscectomy with enhancing possible granulation tissue along the left L5/S1 sub-articular recess with mild posterior displacement of the descending L5/S1 nerve roots. There were posterior disc bulges at L3/4 and L4/5 resulting in mild bilateral neuroforaminal narrowing. The 12/4/14 treating physician report cited radicular low back pain up to grade 9/10 with burning, throbbing, and occasional pins and needles. Lumbar spine exam documented moderate loss of range of motion, no tenderness to palpation, and positive straight leg raise on the left at 80 degrees with leg pain. Neurologic exam documented normal strength, some decreased S1 sensation, and diminished left Achilles reflex. The MRI report suggested some scarring around the surgical area with some disc protrusions at the level above. The treatment plan recommended physical therapy and discussed the possibility of surgery. Records documented recent conservative treatment to include medications, physical therapy, and chiropractic. The injured worker continued at full duty status. The 8/27/15 treating physician report cited persistent severe grade 9/10 left thigh pain radiating down his leg. Pain is worsened

with activity and improved with rest. Physical exam documented significant left paraspinal and lumbosacral junctional tenderness to palpation with moderately restricted range of motion. Straight leg raise on the left caused significant back pain at 80 degrees. There was some decreased S1 dermatomal sensation, slightly decreased left S1 reflex, and intact motor strength. Imaging was reviewed and showed no compressive lesion for that left S1, but he did have disc degeneration at L5/S1 with loss of disc height and a disc protrusion. Conservative treatment included physical therapy, lumbar epidural steroid injection, trigger point injections, chiropractic therapy, and medications. The injured worker continued to work regular duties. Authorization was requested for front and back fusion at the L5/S1 level. The 9/16/15 utilization review non-certified the request for front and back fusion at the L5/S1 level as there was no documentation that the injured worker had exhausted conservative management, including recent lumbar corticosteroid injections, and no evidence of a pre-surgical psychological evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Front and Back Fusion at the L5-S1 Levels: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers Compensation, Online Edition, 2015, Low Back, 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, 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. 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 low back pain radiating down his left leg. Clinical exam findings are consistent with imaging evidence of plausible neural compression at the L5/S1 level. However, there is no documentation of a worsening or significant neurologic deficit or functional limitation. Detailed evidence of failure of recent reasonable and/or comprehensive non-operative treatment has not been submitted. 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 intraoperative instability and necessitate fusion. There is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.