MAXIMUS Federal Services

Case Number:	CM15-0209563		
Date Assigned:	10/28/2015	Date of Injury:	10/23/2008
Decision Date:	12/10/2015	UR Denial Date:	10/08/2015
Priority:	Standard	Application Received:	10/23/2015

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 60-year-old male who sustained an industrial injury on 10/23/08. Injury occurred when he was lifting a machine. Past medical history was positive for hypertension, gastritis, anxiety/stress, and depression. Conservative treatment for this injury had included medication management, chiropractic, acupuncture, physical therapy, interferential unit, psychotherapy, home exercise, lumbar facet joint injections, and activity modification. The 2/11/14 lower extremity EMG/NCV study documented electromyographic evidence suggestive of denervation of the left L5/S1 innervated muscle, consistent with left sided L5/S1 radiculopathy and clinical correlation was suggested. The 3/14/14 lumbar spine MRI impression documented early disc desiccation at the L5/S1 level, and grade 1 retrolisthesis of L5 over S1. At L4/5, there was diffuse disc protrusion with effacement of the thecal sac. Disc material and facet hypertrophy caused bilateral neuroforaminal stenosis that encroached upon the left and right exiting L4 nerve roots. At L5/S1, there was a focal central chondromalacia patella superimposed on diffuse disc bulge and annular tear indenting the thecal sac. Disc material and facet hypertrophy caused bilateral neuroforaminal stenosis that encroached upon the left and right exiting L5 nerve roots, more so on the left side than the right. The 5/14/15 pain management report indicated the injured worker had significant low back pain and stiffness with radicular lower extremity pain under fair to good control following the L5/S1 epidural steroid injection in January 2015. He had a 40% overall improvement in low back pain with the epidural injection, and 65-70% improvement of radicular lower extremity pain. Lumbar spine exam documented tenderness over L3 to S1 fact joints with positive provocation test, bilateral sacroiliac joint pain to palpation, and severe tenderness over the lumbar spinous processes and

interspaces from L3 to S1. There was limited lumbar flexion and extension and tightness, tenderness and trigger points in the lumbar spine muscles bilaterally. Straight leg raise was positive. There was slightly diminished sensation at the L4, L5 and S1 nerve root distributions, more dense on the left. The left Achilles reflex was diminished. Medications were refilled and authorization was requested for bilateral lumbar medial branch blocks at L3-L5. A prescription for physical therapy was noted on 9/10/15 from the treating physician for 4 visits to the lumbar spine, with treatment initiated on 9/6/15. The 9/15/15 orthopedic surgery report cited upper back and bilateral shoulder pain, neck pain radiating to the bilateral upper extremities, and low back pain with radiation to the bilateral lower extremities. Pain was rated grade 6/10. There had been minimal improvement despite anti-inflammatories, physical therapy, and epidural injections. Physical exam documented paraspinal tenderness to palpation, full range of motion, and no tenderness over the spinous processes. Neurologic exam documented 5/5 lower extremity muscle strength and diminished sensation over the bilateral L5 dermatomes. Imaging documented L4 to S1 stenosis. Authorization was requested for L4-S1 decompression with possible fusion if instability occurs from the decompression. The 10/8/15 utilization review non-certified the request for L4-S1 decompression with possible fusion as there were no objective findings to corroborate L4 radiculopathy, no MRI findings evidencing frank nerve root compromise, no detailed evidence of exhaustive conservative treatment, and no dynamic instability or imaging findings that would suggest the need for wide decompression to the point of inducing iatrogenic instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4 to S1 Decompression with Possible Fusion: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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, 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 low back pain radiating to the bilateral lower extremities. Clinical exams have been consistent with imaging evidence of L4 and L5 nerve root compromise. Detailed evidence of long-term extensive non-operative treatment without sustained improvement 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 imaging evidence 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.