

Case Number:	CM15-0214392		
Date Assigned:	11/04/2015	Date of Injury:	06/11/1996
Decision Date:	12/16/2015	UR Denial Date:	10/23/2015
Priority:	Standard	Application Received:	10/30/2015

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 38-year-old male who sustained an industrial injury on 6/11/96. The mechanism of injury was not documented. He underwent a lumbar fusion at L5/S1 in 1998. The 2/26/13 lumbar spine MRI impression documented 3-4 mm posterior disc bulges at the T12/L1 and L4/5 levels, and 3 mm disc protrusions at the narrowed L1/2 and L3/4 levels. There was severe right L4/5 facet hypertrophy, mild bilateral L4/5 neuroforaminal narrowing, bilateral L5/S1 facet joint fusion, and a benign appearing L4 intraosseous lesion. The 4/13/15 lumbar discogram documented positive findings at L3/4 and L4/5. The 10/7/15 treating physician report cited constant severe low back pain radiating down both legs, worse on the left, and associated with numbness and tingling. He reported the left leg numbness, tingling, and frequency of his left leg giving way had increased since his last evaluation. He also reported a left thigh stabbing sensation. He continued to use a walker on a regular basis due to weakness and giving way of both legs which had resulted in falls. He was not currently working. A TENS unit had been ordered but not provided. He was taking up to 12 Norco 7.5/300 mg per day, 8 tablets of Ultram, and Motrin twice a day. Physical exam documented unbalanced gait with mild to moderate antalgic limp, probable Trendelenburg limp, use of a walker, and significant difficulty getting up from the exam room chair. He had a tendency to stoop forward and had trouble standing up full straight. Lumbar range of motion was restricted, and there was mild to moderate paraspinal spine, severe bilateral SI joint tenderness, and mild sciatic nerve tenderness. There were absent ankle reflexes, 3/5 left extensor hallucis longus weakness, and positive straight leg raise test. The diagnosis included discogenic disease of the lumbar spine at L5/S1 status post decompression and fusion associated with bilateral lower extremity radiculitis, and degenerative

disc disease, facet spondylosis, and positive discogenic disease at L3/4 and L4/5. The injured worker had moderate to severe exogenous obesity (body mass index 40.2) associated with hypertension. The injured worker was advised to get his weight below 300 pounds to decrease the risks associated with surgery. The flexion and extension radiographs did not identify any gross instability at any lumbar level. Authorization was requested for anterior plus posterior lumbar decompression and fusion at L3/4 and L4/5 and associated surgical requests for an assistant surgeon and 12 sessions of post-op physical therapy. The 10/23/15 utilization review noncertified the requests for anterior plus posterior lumbar decompression and fusion at L3/4 and L4/5, an assistant surgeon, and 12 sessions of post-op physical therapy. The rationale for non-certification stated that there was no imaging evidence of pathology at L3/4 as there was no central or lateral spinal stenosis, no discussion that adequate decompression would create iatrogenic instability, imaging was over 2 years old, and psychological evaluation was not documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior plus a posterior lumbar decompression and fusion at L3-4 and L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

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 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. 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 constant severe low back pain radiating down both legs with numbness, tingling, and weakness. Giving way of both legs was reported that had resulted in falls. Clinical exam findings were consistent with imaging evidence of plausible nerve root compromise at the L4/5 level. However, there was no evidence of neural compression at the L3/4 level and imaging was nearly 3 years old. A positive discogram at the L3/4 and L4/5 levels was documented. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure 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. Potential psychological issues are documented, including high level opioid use, with no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.

Associated surgical services: Assistant surgeon: 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: 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 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. 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 constant severe low back pain radiating down

both legs with numbness, tingling, and weakness. Giving way of both legs was reported that had resulted in falls. Clinical exam findings were consistent with imaging evidence of plausible nerve root compromise at the L4/5 level. However, there was no evidence of neural compression at the L3/4 level and imaging was nearly 3 years old. A positive discogram at the L3/4 and L4/5 levels was documented. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure 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. Potential psychological issues are documented, including high-level opioid use, with no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.

Associated surgical services: Post-op physical therapy, 12 sessions (2 X 6): 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: 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 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. 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 constant severe low back pain radiating down both legs with numbness, tingling, and weakness. Giving way of both legs was reported that had resulted in falls. Clinical exam findings were consistent with imaging evidence of plausible nerve root compromise at the L4/5 level. However, there was no evidence of neural compression

at the L3/4 level and imaging was nearly 3 years old. A positive discogram at the L3/4 and L4/5 levels was documented. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure 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. Potential psychological issues are documented, including high level opioid use, with no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.