

Case Number:	CM15-0221163		
Date Assigned:	11/16/2015	Date of Injury:	04/12/2014
Decision Date:	12/28/2015	UR Denial Date:	10/19/2015
Priority:	Standard	Application Received:	11/10/2015

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 28-year-old female who sustained an industrial injury on 4/12/14. Injury occurred when she was trying to sit on a stool and fell onto her left buttock. The 4/17/14 lumbar spine x-ray report documented a 2-3 mm dystrophic calcification, which might represent annulus calcification inferior to the L3 body but otherwise essentially normal limited lumbosacral spine. Conservative treatment included physical therapy, medications, epidural steroid injection, interferential treatment, and activity modification. She underwent an L5/S1 epidural steroid injection on 4/9/15 with up to 50% improvement in her symptoms for approximately 2 weeks. The 9/4/15 lumbar spine MRI impression documented small posterior central disc extrusion at L3/4 causing only mild central stenosis without neuroforaminal stenosis. There was a disc bulge at L5/S1 causing mild bilateral neuroforaminal stenosis. Findings documented disc desiccation with mild disc height narrowing at L5/S1. There was a small disc bulge without significant central stenosis and mild bilateral neuroforaminal stenosis was present due to inferior disc encroachments. There was satisfactory alignment. There were degenerative marrow signal changes present adjacent to the endplates at L5/S1. The 9/11/15 psychological consult report documented a diagnosis of depressive and anxiety disorder with moderate psychosocial stressors. The treatment plan recommended a combination of psychotropic medication and individual counseling treatment, 4 cognitive behavioral therapy sessions, 4 biofeedback therapy treatment sessions, 6 sessions of group therapy, and follow-up every 6 weeks. There was no discussion of her psychological fitness for surgery. The 9/30/15 treating physician report cited incapacitating low back pain and radicular symptoms down the bilateral lower extremities. She had failed over 6 months of conservative treatment, including work modifications, medications,

and epidural steroid injections. Physical exam documented severe painful loss of lumbar range of motion with spasms and guarding. There was decreased L5/S1 dermatomal sensation bilaterally. Imaging showed significant disc desiccation and bony marrow endplate changes at L5/S1 with moderate bilateral foraminal stenosis. Flexion/extension and lateral x-rays previously performed documented spinal instability at the L5/S1 motion segment. The treatment plan requested anterior lumbar decompression and interbody stabilization at the L5/S1 motion segment. The 10/5/15 emergency department report cited a 3-day history of worsened low back pain radiating down her left leg. She had to leave work early today due to pain. She was unable to get her pain medications and presented to get a few days worth of medications. X-rays were obtained and documented disc narrowing and degenerative disease at L5/S1. There was no fracture or dislocation. There was no acute bony abnormality. The 10/7/15 orthopedic surgery appeal letter stated that the injured worker had a progressive radiculopathy with positive straight leg raise and loss of sensation in an L5/S1 distribution. These findings correlate with imaging findings of L5/S1 bilateral foraminal stenosis. Previous flexion/extension x-rays documented spinal instability at the L5/S1 motion segment. She had activity limitation due to her radiating leg pain for more than one motion and had a progression of lower extremity symptoms. Conservative treatment for over 6 months had failed to resolve disabling symptoms. Authorization was requested for anterior lumbar decompression through retroperitoneal exposure with anterior lumbar decompression and stabilization and associated surgical requests for 1 to 2-day inpatient hospital stay and purchase of a lumbar brace. The 10/19/15 utilization review non-certified the anterior lumbar decompression and fusion and associated requests as flexion or extension views were not available to confirm the degree of instability and there was no clear pattern of radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior lumbar decompression through retroperitoneal exposure with anterior lumbar decompression and stabilization: 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).

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 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 down both lower extremities. Functional difficulty precluded return to full duty work. Signs/symptoms and clinical exam findings were reported consistent with imaging findings of L5/S1 bilateral foraminal stenosis. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is no radiographic evidence of spondylolisthesis or spinal segmental instability on flexion and extension x-rays documented consistent with guideline criteria. 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 with no evidence of a psychological clearance for surgery. Therefore, this request is not medically necessary.

Associated Surgical Services: Inpatient hospital stay, 1-2 days: 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.

Associated Surgical Services: Lumbar brace, purchase: 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.