

Case Number:	CM15-0222318		
Date Assigned:	11/18/2015	Date of Injury:	04/07/2011
Decision Date:	12/30/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	11/12/2015

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 32-year-old male who sustained an industrial injury on 4/7/11. The mechanism of injury was not documented. Conservative treatment included opioid pain medication, activity modification, and medical marijuana. The 3/26/15 lumbar x-ray impression documented mild multilevel degenerative disc disease of the lumbar spine. There were age indeterminate compression deformities at T12, L1, and L2, worse at L1 where there was approximately 50% loss of vertebral body height anteriorly. There was fixed retrolisthesis from L1 through L5 without evidence of dynamic instability. The 4/13/15 CT scan impression documented no disc herniation or central canal stenosis at any level. There was mild bilateral neuroforaminal narrowing at L5-S1, which could contribute to L5 radicular symptoms. The 9/24/15 lumbar spine fine cut CT scan impression documented multi-level broad based disk bulges, worst at L5-S1, where there was a 2 mm broad-based disc bulge and moderate bilateral facet arthropathy causing minimal central canal narrowing and moderate to severe bilateral neuroforaminal. There were chronic anterior wedge deformities of L1 and L2 with loss of approximately 50% disc height at L1 and 20% at L2. At L3-4, there was a 2 mm broad-based disc bulge slightly eccentric to the left with mild bilateral facet arthropathy and ligamentum flavum hypertrophy with resultant mild to moderate central canal stenosis and mild bilateral foraminal narrowing. At L4-5, there was a 1-2 mm broad-based disc bulge with mild bilateral facet arthropathy and ligamentum flavum hypertrophy with minimal central canal narrowing and mild bilateral neuroforaminal narrowing. The 9/24/15 spine surgeon report documented sitting, standing, and walking intolerance. Physical exam documented antalgic gait, difficulty in heel and

toe walking on the left, mild lumbar muscle spasms, and L4-S1 tenderness on the left. There was moderate to marked limitation in lumbar range of motion with pain. Neurologic exam documented positive straight leg raise on the left, 4/5 left L5 myotomal weakness, absent left Achilles and patellar reflexes, and trace (1+) right Achilles and patellar reflexes. Imaging was reviewed and showed an L5-S1 disc herniation centrally and more prominent in the left posterolateral recess with marked left and moderately severe right foraminal stenosis. At L4-5, the exiting nerves are involved in the mild stenosis, but there was a subarticular recess due to broad-based disc protrusion, more prominent in the left paracentral area. At L3-4, there was broad-based disc bulging resulting in mild to moderate central and subarticular stenosis. The diagnosis was lumbar spine disc protrusion and spinal stenosis with radiculopathy. The spine surgeon stated that there was very severe foraminal stenosis on the left sided along the entire path of the foramen. This needed to be decompressed and might require facetectomy that would necessitate L5/S1 fusion. Authorization was requested for posterior lateral fusion L5-S1, central decompression L3-S1, and decompression L3-S1. The 10/20/15 utilization review non-certified the request for posterior lateral fusion L5-S1, central decompression L3-S1, and decompression L3-S1 as there was no evidence of radiographic instability and there was significant discrepancy between the surgeon and radiologist's interpretation. The 10/22/15 treating physician report cited low back and leg pain, unchanged. Current medications included duloxetine, Norco 10/325 mg, and medical marijuana. Physical exam documented increased lumbar lordosis and no tenderness. Lower extremity deep tendon reflexes, strength, and straight leg raises were symmetrical. The diagnosis was chronic pain due to trauma, lumbosacral intervertebral disc degeneration, and low back pain. Surgery was being appealed. The treatment plan recommended continued medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior lateral fusion L5-S1, central decompression L3-S1, decompression L3-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

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 low back and leg pain with functional difficulty documented in sitting, standing, and walking. Clinical exam findings documented motor deficit and reflex changes consistent with reported imaging evidence of plausible nerve root compromise. There is discussion of the potential need for wide decompression and facetectomy at L5-S1 that would result in temporary intraoperative instability and necessitate fusion. There is no radiographic evidence of spondylolisthesis or spinal segmental instability on flexion and extension x-rays. Additionally, there is no detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including completion of all physical therapy and manual therapy interventions, and failure. There is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.