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| Case Number: | CM15-0037752 | | |
| Date Assigned: | 03/06/2015 | Date of Injury: | 07/12/2012 |
| Decision Date: | 05/05/2015 | UR Denial Date: | 02/20/2015 |
| Priority: | Standard | Application Received: | 02/27/2015 |

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:

The injured worker is a 59-year-old female with date of injury 7/12/12. Injury was reported due to cumulative trauma while employed as a licensed vocational nurse. The 12/9/10 lumbar spine MRI documented 8 mm anterolisthesis of L4 on L5. At L4, appearance suggested bilateral spondylolysis and which could be further evaluated with high resolution CT scan. At L4/5, there was decreased disc height, disc dehydration, and irregular contour of the disc. There was approximately 7-8 mm anterolisthesis, an 8-9 mm pseudo- and/or true posterior disc protrusion/extrusion, encroachment on the epidural fat and foramina bilaterally, compromised on the traversing and exiting nerve roots bilaterally, and relatively small and satisfactory facet joints. At L5/S1, there was a decrease in disc height, 2 mm posterior disc protrusion encroaching on the epidural fat, no compromise on the traversing or exiting nerve roots, and satisfactory facet joints. The 6/18/14 bilateral lower extremity electrodiagnostic study documented evidence of multilevel lumbosacral radiculopathy, primarily involving the L4/5 nerve roots, not excluding S1, greater on the left. The 8/6/14 psychological progress report documented a diagnosis of depressive disorder with on-going cognitive behavioral therapy. The 10/13/14 treating physician report cited persistent neck pain radiating to her shoulders, and reports that her low back pain was worse. Physical exam documented decreased cervical range of motion with paravertebral muscle tenderness, and decreased bilateral shoulder range of motion with anterior shoulder tenderness and positive impingement signs bilaterally. There was decreased lumbar range of motion with paravertebral muscle tenderness and spasms, and positive straight leg raise at 75 degrees bilaterally. The diagnosis was chronic cervical, dorsal and lumbar strain, dorsal

compression fractures suggested on MRI and CT scan, and grade I-II L4/5 spondylolisthesis per MRI. The treatment plan recommended physical therapy for the neck, bilateral shoulders, and back 2x6, and continued permanent work restrictions. The 2/20/15 utilization review non-certified the request for L5/S1 decompression, posterior instrumented fusion, and possible transforaminal lumbar interbody fusion, pre-op medical clearance with labs and EKG, and post lumbar brace. The rationale for non-certification was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decompressions (lumbar) L5-S1 (sacroiliac); Posterior Instrumented Fusion; Possible Transforaminal Lumbar Interbody Fusion: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Fusion (spinal).

Decision rationale: The California MTUS guidelines recommend lumbar discectomy for carefully selected patients with nerve root compression due to lumbar disc prolapse. Lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there was no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The Official Disability Guidelines recommend criteria for lumbar laminotomy 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. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. This patient presented with low back pain. There was electrodiagnostic evidence of primarily L4/5 radiculopathy consistent with imaging evidence of nerve root compression. There was evidence of a grade I-II L4/5 spondylolisthesis on MRI in 2010 with no current imaging documentation relative to instability. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Records documented that psychological treatment was in process but surgical clearance was not documented. Therefore, this request is not medically necessary at this time.

Pre-Operative Medical Clearance with Labs & EKG (electrocardiogram): 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.

Post-Operative Lumbar Brace (DME): 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.