

Case Number:	CM15-0045559		
Date Assigned:	03/17/2015	Date of Injury:	10/23/1996
Decision Date:	05/05/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	03/10/2015

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:

The injured worker is a 50-year-old male who sustained an industrial injury on 10/30/96. The mechanism of injury was not documented. Records documented conservative treatment to include acupuncture with passive modalities, and medications. The 2/24/14 lumbar spine MRI impression documented abnormal areas of signal intensity in the vertebral body endplates adjacent to the L2/3, T12/L1, and L5/S1 disc spaces, along with inferior endplate of T11 and superior endplate of L4 possibly representing changes of spondyloarthropathy. At L4/5, there was a 1.2 mm disc bulge and facet hypertrophy causing mild canal and mild to moderate bilateral foraminal stenosis. At L5/S1, there was a 2.1 mm disc protrusion and facet hypertrophy causing mild canal stenosis and moderate bilateral foraminal stenosis. There was no instability noted on the flexion and extension images. The 2/6/15 neurosurgical evaluation report cited low back pain and bilateral leg pain, with some intermittent numbness and weakness. Symptoms progressed over the last year. Pain was noted to be incapacitating and sometimes he had to crawl to the bathroom due to severe pain. Physical examination documented paraspinal muscle tenderness and spasms, lumbar flexion essentially 0%, extension 10% of normal and severe pain with forward bending. Straight leg raise was positive on the left. The left Achilles reflex was absent with decreased sensation over the dorsum of the foot, and patchy sensation over the anterior shin. There was breakaway weakness with anterior tibialis and extensor hallucis longus testing on the left at 4/5. MRI flexion/extension showed disruptive disc with severe Modic changes at L4/5 and L5/S1. There was bilateral neuroforaminal narrowing due to facet arthropathy, degenerative disc and disc protrusion at L4/5 and L5/S1 bilaterally. Disruptive changes were severe and consistent

with axial instability. There was failure of conservative management and patient incapacitation to the point where he intermittently had to crawl to the bathroom. He could not sit or stand more than 15-20 minutes without intense pain requiring narcotics or bed rest. Authorization was requested for an anterior and posterior lumbar fusion at L4/5 and L5/S1 with pedicle screws, anterior lumbar interbody fusion, decompression and transverse process fusion. The diagnosis was biomechanical low back pain with axial instability, bilateral radiculopathy with neurologic deficit, lumbar spasticity with myofascial pain, and degenerative lumbar disc at L4/5 and L5/S1. The 3/6/15 utilization review non-certified the request for anterior lumbar interbody fusion and pedicle screws at L4/5 and L5/S1 as there was no documentation of any functional spinal unit failure of instability in the lumbar region.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Lumbar interbody fusion and pedicle screws: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307 and 310.

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 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 in long term from surgical repair. 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 MTUS guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. 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 presents with progressive low back and lower extremity pain, numbness and weakness with severe incapacitation reported at times. Clinical exam findings were consistent with L4/5 and L5/S1 neural compression, which was not documented on the MRI report available in the records. The treating physician documented severe Modic changes with axial instability, but there was no documented imaging evidence of spinal segmental instability or severe changes in the records provided. Detailed evidence of a recent, reasonable and/or

comprehensive non-operative treatment protocol trial, including physical therapy interventions, and failure had not been submitted. A psychosocial evaluation was not evidenced. Therefore, this request is not medically necessary.