

Case Number:	CM15-0050470		
Date Assigned:	03/24/2015	Date of Injury:	08/12/2013
Decision Date:	05/06/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/17/2015

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 61-year-old male who sustained an industrial injury on 8/12/13. Injury occurred when he was working as a car washer when he was sideswiped and crushed between 2 cars. Past medical history was reported positive for hypertension, high cholesterol, diabetes, and arthritis. Records for negative for a psychiatric history with no anxiety or depression. The 2/12/15 treating physician narrative report cited incapacitating back pain, and pain, numbness, and tingling radiating down both lower extremities. Conservative treatment had included physical therapy, work modifications, medications, and a series of epidural steroid injection, which did not relieve his symptoms. Physical exam documented severe lower lumbar spine and lumbosacral junction tenderness, guarding and spasms, and severely limited range of motion with pain. Neurologic exam documented positive straight leg raise bilaterally with loss of sensation in an L5/S1 distribution. There was 4/5 weakness of the L5 nerve root bilaterally. X-rays showed L4/5 and L5/S1 disc degeneration. Flexion/extension x-rays showed instability at L5/S1 with over 6 mm of motion. MRI showed L4/5 spinal stenosis with bilateral compression of the L5 nerve roots bilaterally and severe foraminal stenosis with compression of the L5 and S1 nerve roots at the L5/S1 level. The diagnosis included spinal instability of the L5/S1 segment, disc degeneration L4/5 and L5/S1 with severe spinal stenosis and progressive lower extremity L5/S1 motor and sensory radiculopathy bilaterally, with progressive neurologic deficit. Authorization was requested for anterior lumbar decompression and stabilization at L4/5 and L5/S1 segment, and lumbar spine bone stimulator purchase. The 2/12/15, 3/4/15, and 4/1/15 treating physician report progress reports cited flexion/extension lateral x-rays showed spinal instability at L4/5 and L5/S1. The 2/27/15 utilization review modified the request for anterior lumbar decompression and stabilization at L4/5 and L5/S1 segment to anterior lumbar decompression at L4/5 and L5/S1 and stabilization at L5/S1. The rationale indicated that there was x-ray evidence of

instability to support stabilization at L5/S1 but there was no evidence of instability at L4/5. The associated request for a bone growth stimulator was non-certified as the injured worker was certified for a single level fusion and had no other risk factors to support bone growth stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior lumbar decompression and stabilization at L4-5 and L5-S1 segment: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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 ½ Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The California MTUS guidelines recommend lumbar decompression for carefully selected patients with nerve root compression due to lumbar disc prolapse. MTUS guidelines indicate that lumbar spinal fusion may be considered for patient with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there is 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. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar decompression 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 been met. This patient presents with severe low back pain radiating to both legs with numbness and tingling. Clinical exam findings are consistent with imaging evidence of nerve root impingement. The treating physician report documented x-ray evidence of instability at both the L4/5 and L5/S1 levels across multiple progress reports. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There are no psychological issues documented. The medical necessity of additional stabilization at L4/5 has been documented. Therefore, this request is not medically necessary.

Lumbar spine bone stimulator purchase: Overturned

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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back ½ Lumbar & Thoracic Bone growth stimulators (BGS).

Decision rationale: The California MTUS guidelines are silent regarding bone growth stimulators. The Official Disability Guidelines indicate that bone growth stimulators are under study and may be considered medically necessary as an adjunct to lumbar spinal fusion surgery for patients with any of the following risk factors for failed fusion: 1) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit; (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. Guideline criteria have been met. This patient has been certified for a 2 level lumbar fusion and as a history of diabetes. Therefore, this request is medically necessary.