

Case Number:	CM15-0058173		
Date Assigned:	04/02/2015	Date of Injury:	08/30/2012
Decision Date:	05/13/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	03/26/2015

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: Minnesota, Florida
 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 46 year old male who sustained an industrial injury on 08/30/2012. Diagnoses include lumbar/lumbosacral disc degeneration, lumbar disc displacement, lumbosacral neuritis, and lumbar spinal stenosis. Treatment to date has included diagnostics, medications, physical therapy, acupuncture treatments, chiropractic sessions, extracorporeal shockwave procedure, and epidural steroid injections. A physician progress note dated 02/24/2015 documents the injured worker has ongoing complaints of low back pain radiating to the lower extremities with associated weakness and tingling. Range of motion is restricted with pain. The injured worker has not responded to conservative treatments. The treatment plan is for surgery, postoperative physical therapy, pre-operative medical clearance, post-operative lumbar brace, post-operative cold therapy, and lumbar X rays. Treatment requested is for Anterior/Posterior lumbar discectomy, decompression, and fusion with instrumentation allograft, and bone morphogenetic protein at the following levels: L3-L4, L4-L5, L5-S1, and Length of stay at hospital (unknown length).

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior/Posterior lumbar discectomy, decompression, and fusion with instrumentation allograft, and bone morphogenetic protein at the following levels: L3-L4, L4-L5, L5-S1:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 304-306.

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

Decision rationale: An MRI scan of the lumbar spine performed on 1/24/2014 revealed disc desiccation with mild loss of disc space height at L3-4, multilevel disc protrusions, posterior element hypertrophy and neural foraminal stenosis, and no central canal stenosis at any level. At L3-4 there was a broad-based 1.3 mm disc protrusion which became more focal in the far left paracentral region where it measured 2.8 mm. There was mild bilateral facet joint and ligamentum flavum hypertrophy. There was mild right and moderate left neural foraminal stenosis. At L4-5 there was a broad-based 2.1 mm disc protrusion flattening the thecal sac anteriorly. There was mild bilateral facet joint and ligamentum flavum hypertrophy. No central canal stenosis was seen. There was moderate bilateral neural foraminal stenosis. At L5-S1 there was a broad-based 1.8 mm disc protrusion flattening the thecal sac anteriorly without central canal stenosis. There was mild bilateral facet joint hypertrophy. There was mild-to-moderate bilateral neural foraminal stenosis. Electrodiagnostic examination of March 26, 2013 revealed a chronic bilateral S1 nerve root impingement. A discogram of January 28, 2015 revealed an unequivocal positive discogram at L3-4 and L5-S1 with completely negative controls at L2-3 and L4-5. A CT of the lumbar spine performed after the discogram revealed normal nuclear morphology at L4-5. At L3-4 there was a dominant central anterior radial fissure extending to the outer third with no extravasation of contrast. Findings were consistent with a grade 4 disc. At L5-S1 there was a left central radial annular fissure identified extending to the outer third and involving greater than 30 of the disc circumference with no extravasation of contrast material into the ventral epidural space. Findings were consistent with a grade 4 disc. California MTUS guidelines indicate patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. According to table 12.8 on page 310 the guidelines indicate spinal fusion is not recommended in the absence of fracture, dislocation, complications of tumor, or infection. The available documentation does not indicate the presence of any of these conditions. As such, the request for spinal fusion is not supported. Bone morphogenetic protein is not recommended by ODG guidelines. There is a lack of clear evidence of improved outcomes with BMP and there is inadequate evidence of safety and efficacy to support routine use. There is a strong association between treatment with BMP and the incidence of a wide variety of cancers, based on a large lumbar fusion trial. As such, the request for BMP is not supported. In light of the above, the surgical request as stated for anterior/posterior lumbar discectomy, decompression, and fusion

with instrumentation, allograft and BMP at L3-4, L4-5, and L5-S1 is not supported by guidelines and the medical necessity of the request has not been substantiated.

Length of stay at hospital (unknown length): 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): s 307 and 310.

Decision rationale: Since the primary surgical procedure is not medically necessary, the associated surgical requests are also not medically necessary.