MAXIMUS Federal Services

Case Number:	CM15-0083197		
Date Assigned:	05/05/2015	Date of Injury:	06/20/2014
Decision Date:	06/04/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/30/2015

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 56-year-old male who sustained an industrial injury on 6/20/14. Injury occurred when the patient was climbing down a ladder and the ladder slid out from under him. He fell approximately 11 feet, 8 inches onto a concrete slab. The 6/24/14 lumbar spine x-rays documented severe degenerative disc disease from L2 through L5 with an old anterior wedging compression fracture at L1. He underwent left knee arthroscopic partial medial and lateral meniscectomy and chondroplasty on 12/2/14. The 3/10/15 spine surgery initial report cited low back pain radiating to the left leg. Conservative treatment had included anti-inflammatory medication, left knee arthroscopy, physical therapy, and epidural injection. The patient was reported as a smoker. Physical exam documented lumbar paraspinal tenderness to palpation, full range of motion, and normal lower extremity strength and deep tendon reflexes. Sensation was decreased over the left L4 dermatome. Straight leg raise was negative. Lumbar MRI was reviewed and showed L4/5 stenosis and L1 compression fracture. The treatment plan recommended L4/5 decompression, possible fusion, and kyphoplasty at L1. The 3/30/15 lumbar spine MRI impression documented a compression fracture of the L1 vertebral body with approximately 60% vertebral body loss. There were 2-3 mm broad-based posterior disc protrusions from L1 through S1 resulting in bilateral neuroforaminal narrowing and canal stenosis in junction with facet joint hypertrophy. Bilateral exiting nerve root compromise was documented at each level from L1/2 to L5/S1. The 4/2/15 utilization review non-certified the request for L4/5 decompression and fusion and associate physical therapy based on an absence of evidence of spinal instability and psychosocial screen. The request for kyphoplasty at L1 was

non-certified as the compression fracture was old and did not meet guideline criteria. The 4/8/15 treating physician appeal report cited agreement with the non-certification of the request for kyphoplasty as the L1 compression fracture was an old fracture. He reported that imaging looked like the L1 compression fracture had healed. The treating physician report stated that the indication for lumbar decompression was for nerve decompression and fusion was only necessary as he anticipated having to remove more than 50% of the facets. A psychosocial evaluation was not necessary, as the indication was not for axial low back pain. Appeal of the L4/5 decompression and fusion was requested. Additionally, a request for left total knee replacement was submitted given the failure of operative and non-operative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decompression and Fusion at L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The California MTUS guidelines recommend decompression for lumbosacral nerve root decompression. MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. 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 may be supported for surgically induced segmental instability but pre-operative guidelines recommend completion of all physical therapy and manual therapy interventions, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. For any potential fusion surgery, it is recommended that the patient refrain from smoking for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been met. This patient presents with low back pain radiating to the left leg. There was no specific radicular pattern noted. Clinical exam evidence did not evidence motor deficit, reflex change or positive nerve tension signs. There was decreased dermatomal sensation noted on the left at L4. The need for possible fusion was anticipated due to the need to remove more than 50% of the facets resulting in temporary intraoperative instability. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, clinical exam does not correlate with imaging evidence of significant disc disease with bilateral nerve root compromise at all levels from L1/2 to L5/S1. There was no discussion of psychological history or evidence of a psychosocial screen. The patient was noted

to be a current smoker with no discussion documented relative to smoking cessation. Therefore, this request is not medically necessary.

Kyphoplasty at L1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Version, Kyphoplasty, Indications for Surgery - Kyphoplasty.

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 Lumbar & Thoracic: Kyphoplasty.

Decision rationale: The California MTUS guidelines do not provide recommendations for this procedure. The Official Disability Guidelines state that kyphoplasty (vertebral augmentation) is recommended as an option for patients with pathologic fractures due to vertebral body neoplasms, who may benefit from this treatment, but under study for other vertebral compression fractures, and if used for osteoporotic compression fractures should be restricted to selected patients failing other interventions (including bisphosphonate therapy) with significant unresolving pain. Surgical indications include presence of unremitting pain and functional deficits due to compression fractures, lack for satisfactory improvement with medical treatment (e.g. medications, bracing, therapy), absence of alternative causes for pain such as herniated disc, affected vertebra is at 1/3 of its original height, and fracture age not exceeding 3 months. Guideline criteria have not been met. This patient presents with imaging evidence of a compression fracture at L1 that is more than 3 months old. The treating physician has reported that this fracture appeared to be healed. There is no clear indication that there was unremitting pain or functional deficit specific to the L1 compression fracture, or that other causes of pain had been ruled-out. Therefore, this request is not medically necessary.

Post-Op Physical Therapy (16-sessions, 2 times per week for 8 weeks for the lumbar spine): 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.