

Case Number:	CM15-0087040		
Date Assigned:	05/11/2015	Date of Injury:	12/13/2005
Decision Date:	06/11/2015	UR Denial Date:	04/22/2015
Priority:	Standard	Application Received:	05/06/2015

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 68-year-old male who sustained an industrial injury on 12/13/05. Injury occurred when he was in an urgent situation and was required to turn a large rusty 8-inch valve that was stuck. His back snapped when he attempted to forcefully turn it, with immediate onset of back and leg pain. Past surgical history was positive for anterior lumbar discectomy and fusion at L4/5 and L5/S1 on 10/31/07. Past medical history was reported positive for depression, heart disease, hypertension, hiatal hernia, and sexual dysfunction. The injured worker was reported to be a one-pack per day smoker (10/17/14). Conservative treatment had included physical therapy, home exercise program, TENS unit, medications, activity modification, epidural steroid injections, and bilateral sacroiliac injections. The 6/4/14 lumbar spine MRI impression documented status post anterior fusion at L4/5 and L5/S1. There was slight leftward convex curvature of the lower lumbar spine as well as borderline congenital narrowing of the pedicles at L3 and L4. At L3/4, there was a bulge, which was asymmetric to the right as well as facet arthrosis, severe canal narrowing, and moderate to severe bilateral neuroforaminal narrowing. There was associated mild kinking of the cauda equina nerve roots secondary to stenosis at this level. There was mild facet arthrosis at L4/5 and L5/S1 with mild bilateral neuroforaminal narrowing. The 10/17/14 lumbar x-rays showed a solidly healed anterior interbody fusion at L4/5 and L5/S1. There were some degenerative changes that had developed at L3/4 with disc space narrowing and endplate osteophyte formation with some foraminal stenosis. The 4/7/15 treating physician report cited low back pain radiating to both feet. He had known vascular claudication and surgery was recommended but deferred pending completion of his lumbar surgery. Physical exam documented lumbar range of motion with 70

degrees flexion, 20 degrees extension, and 30 degrees lateral bending. Straight leg raise was negative. Neurologic exam documented right quadriceps weakness, normal sensation, and deep tendon reflexes were unobtainable. The 6/4/14 lumbar MRI showed disc degeneration and stenosis at L3/4 above a solid fusion from L4 to S1. The injured worker had symptoms attributable to the L3/4 level above his L4 to S1 fusion, which is fairly common. He had failed conservative treatment. The treatment plan recommended posterior decompression and fusion at L3/4. The 4/22/15 utilization review non-certified the request for L3/4 transforaminal lumbar interbody fusion and associated surgical requests as there was no evidence of a psychosocial screen or radiographic evidence of spinal instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-4 Transforaminal Lumbar Fusion with 3 Day Inpatient Stay: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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: Discectomy/Laminectomy, Fusion (spinal); Hospital length of stay (LOS); Surgical assistant.

Decision rationale: The California MTUS guidelines recommend decompression surgery 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. 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 (ODG) recommended 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. Fusion may be supported for surgically induced segmental instability. 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. 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. The Official Disability Guidelines would support a 3-day inpatient stay for lumbar fusion and an assistant surgeon. Guideline criteria have not been met. This injured worker presented with low back pain radiating to both feet. Clinical exam findings were consistent with imaging evidence of severe canal and neuroforaminal narrowing and nerve root compromise at the L3/4 level. Evidence of reasonable and/or comprehensive non-operative treatment protocol trial and failure was submitted. However, there was no radiographic evidence of spinal segmental instability or discussion of the need for wide

decompression that would result in temporary intraoperative instability. There was evidence that the injured worker was a current one-pack per day smoker with no discussion of smoking cessation. There was no evidence of a psychosocial screen or psychological clearance for surgery. Therefore, this request is not medically necessary at this time.

Medical Clearance: 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.