

Case Number:	CM15-0087152		
Date Assigned:	05/11/2015	Date of Injury:	09/30/2007
Decision Date:	06/11/2015	UR Denial Date:	04/29/2015
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 51-year-old male who sustained an industrial injury on 9/30/07. Injury was reported relative to cumulative trauma as a fire engineer. Past surgical history was positive for C5-7 anterior cervical discectomy and fusion on 6/15/12. Past medical history was positive for depression. The 12/1/09 lumbar spine MRI impression documented a mottled appearance to the lumbar vertebra, 1 cm hemangioma in L5 and a 3 mm hemangioma in the anterosuperior aspect of L3. There was multilevel discogenic disease. At L3/4, there was a 2-3 mm disc protrusion that touched the thecal sac but did not compromise the traversing nerve roots. Findings were consistent with annular tear/fissure and there was encroachment on the foramina with compromise of the exiting nerve roots bilaterally. At L4/5, there was decreased disc height and a 4-5 mm posterior disc protrusion/extrusion with encroachment on the thecal sac and on the foramina bilaterally. There were Modic changes in the adjacent vertebral body end plates. There was compromise on the exiting nerve roots, as well as on the traversing nerve roots bilaterally. There was a 3 mm anterior disc protrusion with encroachment on the anterior longitudinal ligament. At L5/S1, there was a 3 mm posterior disc protrusion with findings consistent with an annular tear/fissure. There was mild encroachment on the epidural fat without compromise of the traversing nerve roots. There was encroachment on the foramina with compromise on the exiting nerve roots bilaterally. The 4/17/15 orthopaedic surgery report cited on-going neck and posterior mid scapular pain, and increased numbness and tingling in the upper extremities and increased pain, numbness and tingling in the bilateral lower extremities. Pain radiated from the posterior buttocks to the posterior thighs, lateral calves and dorsal aspect of the feet. There was persistent

right great toe numbness. Physical exam documented 4+/5 bilateral extensor hallucis longus and anterior tibialis strength, decreased sensation dorsal aspects of the feet, lumbar flexion 50 degrees, and extension 30 degrees. The lumbar spine MRI showed disc desiccation and fairly significant advanced collapse of the L4/5 disc. There was herniation at this level with up-down collapse, foraminal stenosis, and facet hypertrophy. The diagnosis included advanced L4/5 lumbar disc disease at L4/5 with herniation and collapse, and foraminal stenosis with worsening bilateral lumbar radiculopathy. The orthopaedic surgeon opined that he was doing fairly poorly from a clinical standing relative to the lumbar spine and had failed prior conservative treatment including therapy, medications, and injections. The treatment plan recommended lumbar decompression and instrumented fusion limited to one level at L4/5 where the pathology was worse. Authorization was requested for anterior lumbar discectomy and fusion, allograft, screw fixation, posterior lumbar decompression, and fusion; pre-operative labs; pre-operative medical clearance; post-operative physical therapy for the lumbar spine; and a lumbar corset. The 4/29/15 utilization review non-certified the request for anterior lumbar discectomy and fusion, allograft, screw fixation, posterior lumbar decompression and fusion (intertransverse and inner body), pre-operative testing and pre-operative medical clearance. The rationale indicated that the patient had been previously certified for L4-S1 lumbar decompression and fusion and those records were unclear what levels were being requested, and a pain management consult had just been certified with no indication that this had been complete and what the treatment recommendations were.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Lumbar Discectomy and Fusion, Allograft, Screw Fixation, Posterior Lumbar Decompression, Fusion (Intertransverse and Inner Body): 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).

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. 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 surgery 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. Guideline criteria have not been met. This injured worker presents with persistent low back pain radiating to the lower

extremities with constant right great toe numbness. Clinical exam findings are consistent with 2009 imaging evidence of multilevel nerve root compromise at L4, L5, and S1. There is no radiographic evidence of spinal segmental instability. There is no discussion of the need for wide decompression and potential for temporary intraoperative instability. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. The records reflect potential psychological issues which are not addressed in the current records, but for a diagnosis of depression. There is no evidence of a recent psychosocial screen or psychological clearance for surgery. The specific level for this surgical request is not documented. Therefore, this request is not medically necessary at this time.

Pre-Op Labs to Include CBC, BMP, PT/PTT, UA and Nasal Swab MRSA Labs/EKG/Chest X-Ray: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for pre-anesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3): 522-38.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-Op Medical Clearance: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI), Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun, page 40.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.