

Case Number:	CM15-0088929		
Date Assigned:	05/13/2015	Date of Injury:	07/23/2010
Decision Date:	06/12/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/08/2015

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 53-year-old male who sustained an industrial injury on 7/23/10. The injured worker reported an onset of left leg and low back pain as he stepped off a forklift. Past medical history was positive for diabetes mellitus and hypertension. Past surgical history was positive for left L3-5 laminectomies, facetectomies, foraminotomies, and discectomies, and posterior L4/5 fusion on 11/10/11. The 2/18/13 lower extremity electrodiagnostic study impression documented mixed neuropathy most likely diabetic, and prolonged bilateral H-reflex maybe secondary and metabolic disorders (diabetes mellitus) vs. previous back surgery vs. S1 radiculopathy. There was mild chronic left L5 radiculopathy. The 6/11/14 lumbar spine MRI findings documented a slight retrolisthesis of L3 on L4 with congenital narrowing of the canal and a posterior disc protrusion similar to previous exam although the measurement was less. There was bilateral facet arthropathy and neuroforaminal narrowing, central stenosis, and Schmorl's node, all similar to previous exam. The 1/12/15 chiropractic medical examiner report documented moderate to marked depression and moderate anxiety on psychological testing. The 3/2/15 neurosurgical report cited low back pain radiating down both legs, left greater than right, with weakness and a sensation of feeling off balance. He also complained of numbness and tingling. Pain was managed with Tramadol, Norco, and Neurontin. Physical exam documented 4/5 strength for the iliopsoas, quadriceps, plantar flexors, dorsiflexors, and extensor hallucis longi with no atrophy. Lower extremity deep tendon reflexes were +1 and symmetrical. There were no pathological reflexes. Gait was normal and he was able to heel/toe walk and squat and stand without assistance. Lumbar range of motion was normal with positive bilateral straight leg

raise. The 6/11/14 lumbar spine MRI showed L1/2 to L5/S1 degenerative disc disease with slight retrolisthesis at L3/4. The treatment plan noted discussion of an L3/4 fusion and recommended x-rays and CT scan of the lumbar spine. The 4/15/14 treating physician report cited grade 8/10 lower back pain. The injured worker ambulates with a moderately antalgic gait with the use of a single point cane. Physical exam documented moderately antalgic gait using a single point cane, and active forward flexion to 45 degrees, extension to 10 degrees, and bilateral lateral flexion to 15 degrees. The diagnosis included lumbar spinal stenosis without neurogenic claudication, and lumbar intervertebral disc displacement without myelopathy. The treatment plan requested lumbar x-rays and lumbar spine CT scan as recommended by the neurosurgeon. Authorization was requested for L3/4 fusion. The 4/21/15 lumbar CT scan impression documented varying degrees of degenerative disc disease mostly of the lumbar intervertebral space. At L3/4, there was a mild posterior disc protrusion with moderate ligamentum flavum thickening and mild facet arthropathy. There was a small focal bony spur at the posterolateral right margin of the lower plate at L3/4. Central stenosis was suggested. At L4/5, there was an annular disc bulge with posterior bony spur at the interspace projecting centrally and slightly greater to the right. There was effacement of the adjacent anterior thecal sac along with moderate facet arthropathy and encroachment. There was mild retrolisthesis of L4 on L5 and L3 on L4. The 4/28/15 utilization review non-certified the request for transforaminal lumbar interbody fusion L3/4 with 3-day inpatient stay based on an absence of documented spinal instability and no documented psychological examination.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal lumbar interbody fusion L3-4 with a 3 day inpatient stay (LOS): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 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 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) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Guidelines state that spinal fusion is recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria. 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. The ODG would support up to 3 days length of stay for patients undergoing lumbar fusion. Guideline criteria have not been met. This injured worker presents with low back and bilateral lower extremity pain with reported numbness, tingling, and weakness. There is no focal neurologic deficit identified on the clinical exam. There is imaging evidence of degenerative disc disease, facet arthropathy, central stenosis and mild retrolisthesis at L3/4. There is no radiographic evidence of spinal segmental instability at this level. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is documentation suggestive of potential psychological issues with no evidence of psychological clearance for surgery. Therefore, this request is not medically necessary