

Case Number:	CM15-0089232		
Date Assigned:	05/13/2015	Date of Injury:	03/15/2012
Decision Date:	06/24/2015	UR Denial Date:	04/15/2015
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 50-year-old male who sustained a work related injury on 3/15/12, relative to a side-impact motor vehicle accident. Past medical history was positive for hepatitis C, gastrointestinal disorder, history of peptic ulcer, and hypertension. Social history documented on 10/2/14 that he smoked a half pack of cigarettes a day. Past surgical history was positive for L5/S1 laminectomy on 2/7/14 with worsened low back and right low pain noted as of 4/16/14. Conservative treatment included medications, chiropractic, physical therapy, and medications. The 1/28/15 psychology report documented diagnoses including major depressive disorder (single episode mild), and generalized anxiety disorder. Cognitive behavioral psychotherapy was recommended weekly for 6 months. The 3/10/15 lumbar spine MRI documented spondylotic changes and status post hemilaminectomy of the right L5 vertebral body. At L3/4, there was a 1-2 mm broad-based posterior disc protrusion without evidence of canal stenosis or neuroforaminal narrowing. At L4/5, there was a 2-3 mm posterior disc protrusion, facet joint hypertrophy, and ligamentum flavum redundancy resulting in bilateral neuroforaminal narrowing and canal stenosis with bilateral exiting nerve root compression. At L5/S1, there was a 4-5 mm right paracentral disc protrusion resulting in right greater than left neuroforaminal narrowing and bilateral exiting nerve root compromise. The 4/3/15 treating physician report cited no improvement in symptoms. Lumbar spine exam documented paraspinal tenderness, normal lordosis, and normal range of motion. Sensation was reported diminished in the right L5 dermatome. Imaging showed prior laminectomy with about 50% of the facets removed and recurrent disc herniation at the L5/S1 level. The diagnosis was lumbar radiculopathy. The treating physician report indicated that the injured worker had failed to improve despite anti- inflammatories, physical therapy, injections, and surgical decompression. As the injured worker had a recurrent disc herniation with more than 50% of the facets

removed, the recommendation was for L5/S1 revision decompression and fusion with post-op physical therapy 2x8. The 4/15/15 utilization review non-certified the request for L5/S1 decompression and fusion and associated post-operative physical therapy 2x8 as the injured worker did not have documented significant exam findings. The 5/5/15 treating physician appeal report cited continued low back pain radiating to the right leg. Lumbar spine exam documented paraspinal tenderness, normal range of motion, 5/5 lower extremity strength, normal reflexes, negative Achilles clonus, negative straight leg raise, and decreased right L5 dermatomal sensation. The diagnosis included lumbar radiculopathy. The treating physician report stated that lumbar fusion does on occasion cure low back pain and that a fusion was indicated when there was instability. He reported that the patient had a decompression and already had 50% of his facets removed. Additional decompression will cause temporary intraoperative instability requiring fusion. Appeal was requested for the L5/S1 decompression and fusion. The treating physician was also appealing a denial of a C5/6 anterior cervical discectomy and fusion and provided information in that regard.

IMR ISSUES, DECISIONS AND RATIONALES

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

Postoperative physical therapy for the lumbar spine, twice a week for eight weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

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

Decompression and fusion L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 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 laminectomy 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 laminectomy 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. 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. Guideline criteria have not been met. This injured worker presents with low back pain radiating into the right leg. Clinical exam findings are consistent with imaging evidence of nerve root compromise of the L5 nerve root. There is documentation that a wide decompression was planned at L5/S1 creating temporary intraoperative instability and necessitating fusion. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is imaging evidence of additional nerve root compromise at L4/5 that was not discussed in the treating physician reports. The patient was reported as a smoker with no evidence of 6 weeks of smoking cessation consistent with guidelines. Additionally, there are potential psychological issues documented with no evidence of psychological clearance for surgery. Therefore, this request is not medically necessary at this time.