

Case Number:	CM14-0125629		
Date Assigned:	08/11/2014	Date of Injury:	09/04/2012
Decision Date:	09/29/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/07/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 45-year-old male who reported an injury on 09/04/2012. The mechanism of injury was the injured worker was carrying 100 pounds of dolly track and stepped off on a curb and there was a hole. The hole gave way and the injured worker collapsed with low back pain. The injured worker was noted to be a smoker in early 2014. The injured worker underwent a prior L5-S1 fusion in 2003 and a left knee meniscal surgery in approximately 2007. The injured worker underwent a lumbar CT on 10/11/2012 which revealed 4 mm of anterolisthesis of L5 on S1. There was mild to moderate bilateral facet hypertrophy and arthropathy. There was multilevel discogenic disease most pronounced at L4-5 where a 5 mm bulge was present with concern for a co-existent superimposed protrusion and/or extrusion. The bulge at L4-5 in combination with the mild bilateral facet hypertrophy resulted in mild to moderate neural foraminal stenosis without high grade central canal stenosis. The injured worker underwent an MRI of the lumbar spine on 05/19/2014 which revealed a 4 to 5 mm broad-based central disc protrusion with an annular tear at the L4-5 level as seen by a focus of high signal intensity. It extended into the bilateral neural foramina causing mild to moderate bilateral neural foraminal narrowing, right greater than left. There were hypertrophic facet degenerative changes bilaterally. Additionally, the posterior fusion achieved using bilateral pedicle screws at L5-S1 was present. There was no evidence of canal stenosis or neural foraminal narrowing. The prior treatments were noted to include Flexeril, Naprosyn, Ambien, Norco, home exercises, and physical therapy. The injured worker's examination on 07/09/2014 revealed the injured worker had complaints of severe low back pain. The physical examination revealed the injured worker had severe muscle spasm and tenderness along the lower portion of the back at L4 through S1 as well as the superior iliac crest. Motor strength testing was difficult to assess due to severe pain. The physician documented there did not appear to be any significant neural deficit. The injured

worker had more pain on flexion than extension. The injured worker's range of motion in forward flexion was 30 degrees and extension was 25 degrees. The diagnoses included cervical sprain/strain, cervical spondylosis per x-rays at C5-7, status post bilateral shoulder humeral head replacement hemiarthroplasty, status post spinal fusion L5-S1 with adjacent level disease L4-5, bilateral knee patellofemoral chondromalacia, as well as left-sided knee meniscal flap. The treatment plan included the injured worker should start Norco 10/325 mg, Naprosyn, and Flexeril. The injured worker's pain flare seemed to be getting worse. The physician opined the injured worker had clear signs of facet arthritis as well as an annular tear and broad-based disc protrusion at L4-5. It was noted this was an adjacent level of arthrosis that was the source of the pain. The recommendation was for a spinal fusion. The physician opined the injured worker was an ideal candidate for an extreme lateral fusion at L4-5 with instrumentation. There was a Request for Authorization submitted on 07/16/2014 for the requested procedures and ancillary services.

IMR ISSUES, DECISIONS AND RATIONALES

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

XLIF (Extreme Lateral Interbody Fusion) at Level L4-L5 with bone graft and instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation, 18th edition, 2013 updates, Low Back Chapter - Extreme Lateral Interbody Fusion (XLIF).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. The clinical documentation submitted for review indicated the injured worker had a longstanding pain. However, there was a lack of documentation of a failure of conservative care. Electrophysiologic evidence would not be necessary to support a fusion. There was a lack of documentation of flexion and extension x-rays to support instability. There was a lack of documentation including the official MRI report. Additionally, the injured worker was noted to be a smoker in early 2014. There was a lack of documentation indicating the injured worker had stopped smoking. A continuation of smoking could cause failure of a fusion. Given the above,

the request for XLIF (or Extreme Lateral Interbody Fusion) at level of L4-5 with bone graft and instrumentation is not medically necessary.

Assistant Surgeon: 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.

3-5 day inpatient stay: 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.