

Case Number:	CM14-0149445		
Date Assigned:	09/18/2014	Date of Injury:	09/24/2010
Decision Date:	11/14/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/15/2014

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 Orthopaedic Surgery and is licensed to practice in California. 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:

This 61-year-old female program technician sustained an industrial injury on 9/24/10. Injuries occurred as a result of being hit by a truck while a pedestrian. Injuries included upper back, lower back, and mental disorders. The 3/5/13 left lower extremity EMG (Electromyography) was within normal limits. The 9/19/13 spine surgeon report documented positive Waddell torsion and compression tests, patchy decreased non-anatomic sensation, negative sciatic and femoral nerve stretch tests, limited lumbar flexion/extension, and symmetrical trace lower extremity deep tendon reflexes. The diagnosis was L4/5 spinal stenosis with intermittent neurogenic claudication and "severe functional overlay". He opined that due to the lack of response to epidural steroid injection and diffuse constellation of symptoms with no significant positive objective findings, she would not be a good surgical candidate. The 3/4/14 lumbar MRI impression documented no significant changes overall since the previous exam, except for the disc at L4/5 may be minimally smaller. There was a 5-6 mm diffuse disc bulge with slightly short pedicle and ligamentum flavum hypertrophy that contributed to a moderate to high degree of central spinal canal stenosis. There was moderate to severe bilateral foraminal exit zone compromise and facet joint hypertrophy. Correlation was recommended for symptoms of L5 radiculopathy bilaterally. There was a 2-3 mm diffuse disc bulge at L5/S1 with borderline central spinal canal stenosis, bilateral foraminal exit zone compromise, and facet joint hypertrophy. The 7/10/14 treating physician report cited very severe on-going low back pain that radiates down both legs. Coughing was difficult. The patient stated she could not bear the pain any longer. Bilateral lower extremity exam documented 4/5 plantar flexion and dorsiflexion weakness, decreased L5 and S1 sensation, and positive straight leg raise at 10 degrees generating back and bilateral leg pain. She could only bend forward 20 degrees and extend with a significant extension jog. There was quite a bit of cauda equina irritation. The 3/4/14 MRI was reviewed and showed significant disc

damages and settling at the level of the L4/5 with severe spinal stenosis at this level and bilateral foraminal stenosis crushing the cauda equina completely. There was also significant settling at the L5/S1 level. The patient had this pain since 2010 and had completed all courses of non-operative care including physical therapy and epidural steroid injections. The treatment plan recommended an anterior and posterior L4-S1 fusion and decompression. The 8/20/14 utilization review denied the request for lumbar spine surgery as the patient did not have clear clinical findings of neurogenic claudication, had not had comprehensive nonsurgical treatment (i.e. facet injections), and had poor psychological risk factors for surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior decompression and fusion at L4-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal)

Decision rationale: The ACOEM Revised Low Back Disorder guidelines recommend decompression surgery as an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability has been proven. The Official Disability Guidelines recommend criteria for lumbar discectomy and 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 but pre-operative guidelines recommend completion of all physical medicine and manual therapy interventions and psychosocial screen with all confounding issues addressed. Guideline criteria have not been met. There is no radiographic evidence of spinal segmental instability or anticipated surgically induced segmental instability. There is no clear nerve root compression documented on the MRI report of 3/14/14, in contrast to the treating physician interpretation of complete crushing of the cauda equina. The patient has significant psychosocial issues documented and is under on-going psychosocial treatment. There is no evidence of a psychological clearance for fusion surgery. Therefore, this request of anterior decompression and fusion at L4-S1 is not medically necessary and appropriate.

Posterior decompression and fusion at L4-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal)

Decision rationale: The ACOEM Revised Low Back Disorder guidelines recommend decompression surgery as an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability has been proven. The Official Disability Guidelines recommend criteria for lumbar discectomy and 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 but pre-operative guidelines recommend completion of all physical medicine and manual therapy interventions and psychosocial screen with all confounding issues addressed. Guideline criteria have not been met. There is no radiographic evidence of spinal segmental instability or anticipated surgically induced segmental instability. There is no clear nerve root compression documented on the MRI report of 3/14/14, in contrast to the treating physician interpretation of complete crushing of the cauda equina. The patient has significant psychosocial issues documented and is under on-going psychosocial treatment. There is no evidence of a psychological clearance for fusion surgery. Therefore, this request of posterior decompression and fusion at L4-S1 is not medically necessary and appropriate.

Pre-op surgical clearance to include EKG, BCB, and Chest x-ray: 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.

Post-operative Home Health Evaluation: 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.

Post-operative Home Health Care (weeks): 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.