

Case Number:	CM14-0203105		
Date Assigned:	12/15/2014	Date of Injury:	04/18/2012
Decision Date:	01/31/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/04/2014

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, has a subspecialty in Spine 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:

The patient is a 56 year old male who sustained a work related injury to his back, bilateral shoulders and wrists while loading/unloading drums from a trailer according to the injured worker on 4/18/2012. The diagnoses include lumbar degenerative disc disease, right wrist sprain/strain, thoracic strain, and lumbar myalgia. No past surgical intervention to the lumbar area was documented. According to the treating physician's progress reports dated September 22, 2014 the injured worker continues to experience neck, mid and lower back pain, bilateral shoulder and wrist pain. The following diagnostic results were obtained from the Utilization Review determination letter of November 11, 2014. A magnetic resonance imaging from October 2, 2014 documented dessication at L4-5 and L5-S1 with focal central disc protrusion with annular tear superimposed on diffuse disc bulge indenting the thecal sac and disc material and facetectomy hypertrophy causing bilateral neural foraminal stenosis encroaching the left and right L4 and L5 exiting nerve roots was documented. Electromyography and nerve conduction study (NCV) of the lower extremity on November 11/11/14 documented evidence of an acute bilateral L5-S1 lumbosacral radiculopathy. There was no evidence of peripheral neuropathy or entrapment in the lower extremities. The current treatment plan consists of back brace, Norco, Naproxen, and conservative measures and stretching exercises. The injured worker remains on temporary total disability (TTD) since the injury. The treating physician has requested authorization for an anterior lumbar interbody fusion L4-5 and L5-S1; partial discectomy L4-5 and L5-S1, posterior spinal fusion L4-S1. On November 21, 2014 the Utilization Review denied certification for an anterior lumbar interbody fusion L4-5 and L5-S1; partial discectomy L4-5 and L5-S1 and posterior spinal fusion L4-S1. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS) ACOEM and Official Disability Guideline (ODG) Guidelines Low Back Complaints.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Lumbar Interbody Fusion (ALIF) L4-L5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fusion (spinal)

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 Discectomy/laminectomy and Fusion (spinal).

Decision rationale: MTUS reference to ACOEM identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Failure of conservative treatment; and an Indication for fusion (instability (anteroposterior motion of one vertebra over another that is greater than 4.5 mm in the lumbar spine) OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminotomy/fusion. ODG identifies documentation of Symptoms/Findings which confirm presence of radiculopathy, objective findings that correlate with symptoms and imaging findings in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression/laminotomy. Within the medical information available for review, there is documentation of diagnoses of lumbar degenerative disc disease, right wrist sprain/strain, thoracic strain, and lumbar myalgia. In addition, given documentation of objective (4/5 motor strength in left extensor hallucis longus and gastrocnemius and Achilles reflexes 1 bilaterally) findings, there is documentation of accompanying objective signs of neural compromise. Furthermore, given documentation of imaging (lumbar spine MRI (9/21/14) identifying at L4-L5 severe left neural foraminal narrowing and moderate spinal canal stenosis and at L5-S1 severe bilateral neural foraminal narrowing with likely impingement of the exiting nerve roots), there is documentation of abnormalities on imaging studies (radiculopathy). Lastly, given documentation of conservative treatment (medications, activity modifications, and physical therapy), there is documentation of activity limitations due to radiating leg pain for more than one month. However, despite documentation of subjective (lower back pain) findings, there is no documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy). In addition, despite documentation of imaging (Lumbar Spine MRI (9/21/14) identifying at L4-5 2-3 mm anterolisthesis of L4 on L5), there is no documentation of an indication for fusion (instability (anteroposterior motion of one vertebra over another that is greater than 4.5 mm in the lumbar spine)). Therefore, based on guidelines and a review of the evidence, the request for Anterior Lumbar Interbody Fusion (ALIF) L4-L5 and L5-S1 is not medically necessary.

Partial Discectomy L4-L5 and L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Discectomy/Laminectomy, Official Disability Guidelines (ODG)- Indications for surgery

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

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; and activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, as criteria necessary to support the medical necessity of laminotomy. Within the medical information available for review, there is documentation of diagnoses of lumbar degenerative disc disease, right wrist sprain/strain, thoracic strain, and lumbar myalgia. In addition, given documentation of objective (4/5 motor strength in left extensor hallucis longus and gastrocnemius and Achilles reflexes 1 bilaterally) findings, there is documentation of accompanying objective signs of neural compromise. Furthermore, given documentation of imaging (Lumbar Spine MRI (9/21/14) identifying at L4-L5 severe left neural foraminal narrowing and moderate spinal canal stenosis and at L5-S1 severe bilateral neural foraminal narrowing with likely impingement of the exiting nerve roots), there is documentation of abnormalities on imaging studies (radiculopathy). Lastly, given documentation of conservative treatment (medications, activity modifications, and physical therapy), there is documentation of activity limitations due to radiating leg pain for more than one month. However, despite documentation of subjective (lower back pain) findings, there is no documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy). Therefore, based on guidelines and a review of the evidence, the request for Partial Discectomy L4-L5 and L5-S1 is not medically necessary.

Posterior Spinal Fusion L4-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Low back, Fusion (spinal)

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 Discectomy/laminectomy and Fusion (spinal).

Decision rationale: MTUS reference to ACOEM identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Failure of conservative treatment; and an Indication for fusion (instability (anteroposterior motion of one vertebra over another that is greater than 4.5 mm in the lumbar spine) OR a statement that decompression will create surgically induced instability), as criteria

necessary to support the medical necessity of laminotomy/fusion. ODG identifies documentation of Symptoms/Findings which confirm presence of radiculopathy, objective findings that correlate with symptoms and imaging findings in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression/laminotomy. Within the medical information available for review, there is documentation of diagnoses of lumbar degenerative disc disease, right wrist sprain/strain, thoracic strain, and lumbar myalgia. In addition, given documentation of objective (4/5 motor strength in left extensor hallucis longus and gastrocnemius and Achilles reflexes 1 bilaterally) findings, there is documentation of accompanying objective signs of neural compromise. Furthermore, given documentation of imaging (lumbar spine MRI (9/21/14) identifying at L4-L5 severe left neural foraminal narrowing and moderate spinal canal stenosis and at L5-S1 severe bilateral neural foraminal narrowing with likely impingement of the exiting nerve roots), there is documentation of abnormalities on imaging studies (radiculopathy). Lastly, given documentation of conservative treatment (medications, activity modifications, and physical therapy), there is documentation of activity limitations due to radiating leg pain for more than one month. However, despite documentation of subjective (lower back pain) findings, there is no documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy). In addition, despite documentation of imaging (Lumbar Spine MRI (9/21/14) identifying at L4-5 2-3 mm anterolisthesis of L4 on L5), there is no documentation of an indication for fusion (instability (anteroposterior motion of one vertebra over another that is greater than 4.5 mm in the lumbar spine)). Therefore, based on guidelines and a review of the evidence, the request for Posterior Spinal Fusion L4-S1 is not medically necessary.