

Case Number:	CM15-0111805		
Date Assigned:	06/18/2015	Date of Injury:	09/18/2010
Decision Date:	07/16/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	06/09/2015

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 64-year-old female who sustained an industrial injury on 9/18/10, relative to a slip and fall. Past medical history was positive for hypothyroidism, depression and anxiety. Social history documented she was a non-smoker. Past surgical history was positive for anterior cervical discectomy and fusion C5/6 on 12/4/13. The 11/19/13 lumbar spine MRI impression documented multilevel degeneration particularly at L2/3 through L5/S1 with mild levoscoliosis. At L2/3, there was diffuse disc bulge, mild right and mild to moderate left foraminal narrowing, and no significant canal stenosis. At L3/4, there was a diffuse disc bulge, mild facet arthropathy, and mild foraminal narrowing bilaterally. At L4/5, there was a diffuse disc bulge/osteophyte complex measuring up to 3 mm with mild to moderate facet arthropathy. There was no significant central canal stenosis and moderate bilateral neuroforaminal. At L5/S1, there was a 2 mm broad-based disc bulge slightly asymmetric to the left with mild to moderate facet arthropathy, and mild left foraminal narrowing. The 2/2/15 treating physician report cited continued low back pain and increasing bilateral lateral leg pain. Symptoms included leg weakness, leg cramping, and difficulty lying down and walking. She was using a cane to walk. Physical exam documented weakness both legs, positive straight leg raise on the right, right great toe weakness, increased pain with extension, positive paraspinal spasms, and decreased range of motion. The diagnosis included lumbar herniated nucleus pulposus. The treatment plan recommended refills of Norco and Tramadol. Authorization was requested for lumbar fusion. The 4/9/15 medical legal report cited subjective complaints to include constant low back pain radiating to the bilateral anterior and posterior lower extremities to the feet, right greater than left that has worsened. Pain was accompanied by weakness, tingling, and burning sensation, and she experienced bladder and bowel problems. Medications included tramadol, gabapentin, and Vicodin. Physical exam documented moderate to marked loss of range of motion with pain, paraspinal tenderness and spasms, and positive straight leg raise bilaterally. Neurologic lower

extremity exam documented normal reflexes, intact sensation, and normal strength. Lumbar spine x-rays revealed mild demineralization and moderate anterior spondylosis throughout the lumbar spine. At L4/5, there is disc space narrowing with essentially total disc space collapse. There was disc space narrowing at L2/3 and L3/4, and to some degree at L5/S1. The diagnosis included multilevel disc degeneration with lumbar spine stenosis. The AME stated that she continued to have evidence of stenosis with radiculopathy in the lumbar spine and remained a candidate for decompression and fusion. He also recommended psychiatric or psychological counseling for her situational depression and anxiety. Authorization was requested for anterior lumbar interbody fusion at L4/5. The 5/22/15 utilization review non-certified the request for ALIF at L4/5 as there was no documentation of translational spinal instability, electrodiagnostic testing, nicotine status, or psychosocial assessment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior lumbar interbody fusion at L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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 ½ Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The California MTUS guidelines recommend laminotomy, laminectomy, and discectomy 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 decompression 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 is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. 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. Guideline criteria have not been met. This injured worker presents with constant low back pain radiating to the bilateral lower extremities. Clinical exam findings have been reported as consistent with lumbar stenosis and radiculopathy. There is no clear imaging evidence of nerve root compression and no electrodiagnostic evidence to support radiculopathy. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no imaging evidence of spinal segmental instability or discussion of the need for wide decompression to support the need for fusion. Additionally, there are psychological issues documented and no evidence of a psychosocial screen or clearance for surgery. Therefore, this request is not medically necessary.