

Case Number:	CM15-0127428		
Date Assigned:	07/14/2015	Date of Injury:	01/13/2010
Decision Date:	08/10/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	07/01/2015

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:

This injured worker is a 74-year-old female who reported an industrial injury on 1/13/10, relative to a slip and fall. Past medical history was positive for cardiac conditions, gastroesophageal reflux disease, and anxiety/depression. Past surgical history was positive for L5/S1 anterior lumbar interbody fusion with L3/4 and L4/5 XLIF on 9/7/10, and L3-S1 segmental pedicle screw and rod fixation, reduction L3/4 spondylolisthesis, posterolateral fusion L3-S1, complete L3 and L4 laminectomy, and bilateral L3, L4, and L5 foraminotomy on 9/9/10. The 9/24/14 lumbar spine CT scan impression documented prior posterior spinal fusion of L3-S1 with laminectomies at L3 and L4. There was solid bony bridging at L5/S1, and mild bony bridging at L3/4 and L4/5. There was moderate spinal stenosis at L2/3 due to a disc bulge and ligamentum flavum redundancy, and bilateral foraminal stenosis, greater on the left. The 3/16/15 neurosurgical report cited back and leg pain, worsened since July 2014. The right leg had given way multiple times because of pain. She had severe right-sided back and hip pain radiating down the right leg with numbness and tingling in both legs. Physical exam documented no tenderness, normal range of motion, negative straight leg raise, normal motor function, no atrophy, normal sensation and reflexes, negative Hoffman's, and normal station and gait. She had generalized weakness of the lower extremities with no obvious deficit. The diagnosis was post-laminectomy syndrome, lumbar region. She had undergone multiple pain management injections, including radiofrequency ablation, and physical therapy and massage without improvement. Imaging was reviewed and showed moderate central stenosis, degenerative disc disease, disc space collapse, and facet arthropathy at L2/3, resulting in spinal stenosis and severe right sided neuroforaminal

narrowing. The treatment plan recommended lateral anterior lumbar interbody fusion (ALIF) at the L2/3 level with lateral plate. The 5/26/15 history and physical report cited constant grade 5/10 low back pain radiating into both legs. Pain was increased with lying, sitting, standing, walking, lifting and driving, and interfered with sleep. Pain was alleviated by ice, heat, and massage. Review of systems documented psychological complaints of anxiety, depression, excessive anger, and difficulty sleeping. Physical exam documented normal gait, paraspinal muscle tenderness, painful and restricted lumbar range of motion, positive bilateral straight leg raise, 4/5 iliopsoas weakness, normal sensation, and intact and symmetrical deep tendon reflexes. The treatment plan recommended right L2/3 transforaminal epidural steroid injection. Authorization was requested for lumbar fusion at L2/3, lateral anterior lumbar interbody fusion (ALIF) with lateral plate. The 6/9/15 utilization review non-certified the request for lateral ALIF with plating at L2/3 based on no evidence of a psychosocial screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Fusion/L2-3 Lateral ALIF with Lateral Plate: 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): 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 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 persistent lower back pain radiating into both legs. Clinical exam findings are consistent with imaging evidence of plausible nerve root compression at the L2/3 level. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, an L2/3 epidural steroid injection was noted as pending. There was no radiographic evidence of spinal segmental instability at the L2/3 level. There was no discussion of the need for wide decompression that would result in temporary intraoperative instability and necessitate

fusion. There are psychological factors noted on record review with no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.