

Case Number:	CM15-0129615		
Date Assigned:	07/16/2015	Date of Injury:	02/11/2011
Decision Date:	08/12/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/06/2015

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 52-year-old male who sustained an industrial injury on 2/11/11. Injury occurred when he slipped off the second step of a ladder and landed standing up. He was diagnosed with cervical and lumbar radiculopathy. Past medical history was positive for depression and anxiety. Conservative treatment had included acupuncture, chiropractic therapy, medications, 3 lumbar epidural steroid injections, physical therapy, and medications. The 4/21/15 initial spine surgery report cited grade 7/10 low back pain radiating to both legs. Symptoms began 4 years ago with minimal improvement despite conservative treatment. He was a non-smoker with no current depression or anxiety. Lumbar spine exam documented paraspinal tenderness to palpation, full range of motion, 5/5 lower extremity strength, +2 and symmetric deep tendon reflexes, and sensation diminished over the bilateral L5 dermatomes. Updated MRI was recommended. The 4/29/15 lumbar spine MRI impression documented multilevel disc desiccation from L2 to S1. At L4/5, there was diffuse disc herniation with facet joint and ligamentum flavum hypertrophy causing spinal stenosis, bilateral recess stenosis, and bilateral neuroforaminal narrowing. The 5/12/15 spine surgery report cited no improvement in symptoms. Lumbar spine exam was unchanged. The lumbar MRI was reviewed and showed an L4 to L5 disc herniation with high intensity zone in the posterior annulus causing foraminal stenosis. The injured worker had failed more than a year of conservative treatment. Ultram was prescribed for breakthrough pain. Authorization was requested for L4-5 decompression and fusion and postoperative physical therapy 2 times per week for 8 weeks. The 5/29/15 spine surgery appeal report discussed review of imaging findings showing broad stenosis, consistent with the radiologist's interpretation of diffuse disc herniation causing spinal stenosis as well as canal stenosis, lateral recess stenosis, and bilateral neuroforaminal stenosis. He stated that such broad

stenosis will require decompression with removal of more than 50% of the facets necessitating fusion. He requested authorization of the L4/5 decompression and possible fusion. The 6/16/15 utilization review non-certified the L4/5 decompression and fusion and associated physical therapy as the medical records did not establish evidence of lumbar instability on motion plan film radiographs, the patient had a diagnosis of depression with no evidence of psychological clearance, and smoking status was not documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 decompression and fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 307, 310.

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 low back pain radiating to both legs. Clinical findings are consistent with imaging evidence of L4/5 disc herniation and lateral recess stenosis. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is no radiographic evidence of spinal segmental instability. There is discussion of the need for wide decompression with removal of more than 50% of the facet joint that would result in temporary intraoperative instability necessitating fusion. However, there is documentation in the records of potential psychological issues with no evidence of a psychosocial screening. Therefore, this request is not medically necessary at this time.

Postoperative physical therapy 2 times a week for 8 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.