

Case Number:	CM15-0172623		
Date Assigned:	09/14/2015	Date of Injury:	05/05/2003
Decision Date:	10/16/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	09/01/2015

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 49-year-old female who sustained an industrial injury on 5/3/03, relative to cumulative trauma. Past medical history was positive for depression and anxiety, fibromyalgia, asthma, gastrointestinal and urinary issues due to medications, and temporomandibular joint problems. Conservative treatment had included medications, physical therapy, epidural steroid injection; triggers point injections, and activity modification. The 6/16/15 lumbar spine MRI impression documented a grade 2 anterior spondylolisthesis of L5 on S1 due to bilateral pars defect at this level. There was disc desiccation at L4/5 and L5/S1 with associated loss of disc height at L5/S1. There were Modic type II endplate degenerative changes at the inferior endplate of L3 down to L5, and the superior endplate of L4 down to S1. At L4/5, there was diffuse disc herniation abutting the thecal sac, and disc material and facet hypertrophy caused bilateral neuroforaminal narrowing. At L5/S1, there was an 11 mm disc bulge, which combined with facet hypertrophy, caused bilateral neuroforaminal narrowing with deformity of the bilateral L5 nerve roots. Records indicated that the treating physician progress reports documented escalating low back pain radiating into the right lower extremity with numbness. Physical exam documented generally decreased lumbar range of motion, positive right straight leg raise, and decreased right L5 and S1 dermatomal sensation. Authorization was requested for anterior/posterior lumbar spine fusion at L4-S1 and post-op home health evaluation. The 8/7/15 utilization review non-certified the request for anterior/posterior lumbar spine fusion at L4-S1 and associated post-op home health evaluation as there was no evidence of dynamic spinal instability at any level.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior/Posterior Lumbar Spine Fusion at L4-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic: Fusion (spinal).

Decision rationale: The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy 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. The Official Disability Guidelines do not recommend lumbar fusion for patients with degenerative disc disease, disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or non-specific low back pain. Lumbar spine fusion is recommended as an option for patients with spondylolisthesis (isthmic or degenerative) with instability, and/or symptomatic radiculopathy, and/or symptomatic spinal stenosis when there are on-going symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated e.g. acute traumatic unstable fracture, dislocation, spinal cord injury) and subject to pre-surgical clinical indications below. Fusion may be supported for segmental instability (objectively demonstrable) including excessive motion, as in isthmic or degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, with relative angular motion greater than 15 degrees L1-2 through L3-4, 20 degrees L4-5, 25 degrees L5-S1. Spinal instability criteria includes lumbar inter-segmental translational movement of more than 4.5 mm. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability and/or imaging demonstrating nerve root impingement correlated with symptoms and exam findings, spine fusion to be performed at 1 or 2 levels, psychosocial screening with confounding issues addressed, and smoking cessation for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been fully met. This injured worker presents with persistent low back pain radiating into the right lower extremity with numbness. Clinical exam findings are consistent with imaging evidence of nerve root compromise at the L4/5 and L5/S1 levels. Evidence of long-term reasonable and/or comprehensive non-operative treatment protocol trial

and failure has been submitted. Although there is no radiographic evidence of spinal segmental instability or discussion of the medical necessity of wide decompression, there is imaging evidence of a grade 2 spondylolisthesis at the L5/S1 level and bilateral pars defects. There is no radiographic evidence of spinal segmental instability at the L4/5 level. Potential psychological issues are documented with no evidence of a psychosocial screen. Therefore, this request is not medically necessary.

Post-op Home Health Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC, ODG Treatment. Integrated Treatment/Disability duration Guidelines, Pain (Chronic), Online Version (updated 07/15/15) Home health services, Low Back & Lumbar & Thoracic (Acute & chronic) Online Version (updated 07/15/15), Home health services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.