

Case Number:	CM15-0173303		
Date Assigned:	09/15/2015	Date of Injury:	07/13/2009
Decision Date:	10/16/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	09/02/2015

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 69-year-old female who sustained an industrial injury on 7/13/09, relative to cumulative trauma. Past medical history was positive for diabetes. She underwent left carpal tunnel and cubital tunnel release on 10/1/10, anterior cervical discectomy and fusion at C5/6 on 7/24/11, and anterior cervical discectomy and fusion at C4/5 and C6/7 with anterior osteophyte removal at C2/3 on 1/20/15. The 5/13/15 treating physician report indicated that the patient was complaining about her low back and progressing reasonably well with her neck. The 7/6/15 treating physician report cited low back and left leg pain down the back of the calf but not to the foot. Physical exam documented mild difficulty with transitions, normal gait, and negative straight leg raise testing. She seemed areflexic in the lower extremities. The 7/20/15 lumbar spine MRI impression documented a 6 mm right sided disc bulge at L3/4 with high-grade central canal stenosis, right lateral recess stenosis, and right foraminal stenosis. At L4/5, there was a 4 mm disc protrusion indenting the thecal sac with reduced disc space height and signal, bilateral foraminal stenosis, and high-grade central canal stenosis. At L5/S1, there was a 2-3 mm disc annulus bulge minimally indenting the thecal sac with bilateral foraminal stenosis, central canal stenosis, and facet hypertrophy. The 7/29/15 treating physician report cited increased difficulty with ambulation due to lower back pain and claudication. Physical exam documented difficulty with transitions and normal gait. She seemed areflexic in her lower extremities. Straight leg raise testing was negative. The diagnosis lumbar disc degeneration with bulging and anterolisthesis at L4/5, per plain x-rays and history, and severe spinal stenosis L3/4 and L4/5 with anterolisthesis, with foraminal stenosis at L5/S1. The injured worker was off work. The treating physician opined that physical therapy and epidural steroid injections would not work and would be a waste of time and money. Authorization was requested for L3-L5

transforaminal lumbar interbody fusion and L5/S1 foraminotomies, a CyberTech back brace, and a 3-5 day inpatient hospital stay. The 8/11/15 utilization review non-certified the L3-L5 transforaminal lumbar interbody fusion and L5-S1 foraminotomies and associated requests as there was no neurologic exam to support the medical necessity of surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-L5 transforaminal lumbar interbody fusion and L5-S1 foraminotomies: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Discectomy/laminectomy, Fusion.

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, Discectomy/Laminectomy, 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. 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. 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 met. This injured worker presents with low back pain radiating down the left lower extremity to the back of the calf. Functional difficulty was reported with ambulation due to pain and claudication. There is no detailed clinical exam evidence of a focal neurologic deficit. There is

imaging evidence of plausible neural compression at the L3/4 through L5/S1 levels. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no radiographic evidence of spondylolisthesis or spinal segmental instability on flexion and extension x-rays. There is no discussion supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. There is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.

CyberTech Back Brace: 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.

Inpatient Hospital Stay (3-5 days): 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.