MAXIMUS Federal Services

Case Number:	CM15-0063003		
Date Assigned:	04/08/2015	Date of Injury:	03/04/2014
Decision Date:	06/11/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	04/02/2015

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:

The injured worker is a 38-year-old male who sustained an industrial injury on 3/04/14. Injury occurred while removing some linoleum and plywood flooring with a crowbar. He reported he heard a pop following by knife-like pain in his low back. The 9/8/14 lumbar spine x-ray impression documented slight L4 on L5 retrolisthesis, which did not appear to change in flexion or extension, and mild L5/S1 disc space narrowing. The 2/26/15 treating physician report cited intermittent daily low back pain radiating to the right knee. The injured worker reported his pain was getting worse and he was taking more Norco to control it. He was angry and depressed because of the pain. He reported that all he could really do to manage the pain was lay in bed. He was reported independent in activities of daily living. MRI findings showed annular bulge at L4/5 more prominent on the left, central annular tear at L4/5 with contact of the bilateral nerve roots, posterior displacement of the L5 nerve on the left, canal stenosis and foraminal narrowing. At L5/S1, there was asymmetrical annular bugling worse on the right, right paracentral annular tear, and foraminal narrowing on the right. Physical exam documented slight left dorsiflexion weakness, negative straight leg raise and 2+ deep tendon reflexes. The diagnosis was lumbar herniated nucleus pulposus and degenerative disc disease. Surgery had been requested and authorization was pending. The 3/2/15 orthopedic report indicated that the patient was very frustrated, angry and with severe feelings of hopelessness and appeared to be bordering on despair. He was in constant pain and two orthopedic surgeons and his primary treating physician have recommended he needed surgery to return to any percentage of pre-injury status or have any quality of life without pain. The 3/12/15 utilization review non-certified the request for

anterior instrumented fusion of L4/5 and L5/S1 as there was insufficient evidence of a clinical lumbar radiculopathy, no imaging evidence of a significant neurocompression lesion, and no radiographic evidence of instability to justify the requested procedure. The 4/10/15 lumbar spine CT scan impression documented annular disc bulging at L4/5 and L5/S1 on the order of approximately 2-3 mm. The disc bulge at L4/5 results in central spinal canal and bilateral neuroforaminal stenosis. The remainder of the exam was within normal limits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgical Intervention: 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.

Anterior Instrumented Fusion of L4-5, L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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, Fusion (spinal).

Decision rationale: The California MTUS guidelines state there was no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Guidelines state that spinal fusion is recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. 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 patient presents with low back and lower extremity radicular symptoms. There is reported imaging evidence of nerve root compression at L5, which reasonably correlates with symptoms and clinical exam findings. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no evidence of a

psychological clearance for surgery and potential psychological issues are noted. There is no radiographic evidence of spinal segmental instability on flexion/extension films. Therefore, this request is not medically necessary.

Autograft Bone With or Without Bone Morphogenetic Protein: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back ï¿½ Lumbar & Thoracic: Bone-morphogenetic protein (BMP).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.