

Case Number:	CM15-0066157		
Date Assigned:	04/13/2015	Date of Injury:	07/11/2013
Decision Date:	05/19/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	04/07/2015

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 40-year-old male who sustained an industrial injury on 7/11/13. Injury occurred when he was putting tarps over alfalfa in the rain. He slipped on a cord, twisted and fell, landing on his knees. He underwent extensive lumbar laminectomy left L5/S1 with medial facetectomy, foraminotomy, lateral recess decompression and discectomy on 8/14/14. The 1/30/15 lumbar spine MRI impression documented L5/S1 moderate left neuroforaminal stenosis and mild left lateral recess stenosis. There was mild L4/5 bilateral neuroforaminal stenosis. Post-operative changes were consistent with L5/S1 laminectomy and microdiscectomy. There was severe degenerative disc disease of L5/S1 with broad posterior disc protrusion and far lateral zone disc osteophyte complexes. The 2/6/15 lumbar x-rays impression documented severe L5/S1 disc space narrowing, and otherwise negative lumbar spine. The 2/15/15 treating physician report cited continued severe low back pain with severe stiffness to the point where he felt paralyzed. He had radiating pain down to his left foot and up to his right neck. Medications helped alleviate some of the pain and helped him move better. Physical exam documented limited lumbar range of motion, positive straight leg raise on the right, and lumbar spine pain and tenderness. He had diffuse tenderness and crepitus in both knees. The diagnosis included status post lumbar laminectomy L5/S1. The treatment plan recommended neurosurgical follow-up. The 2/25/15 neurosurgical report indicated that the lumbar spine MRI demonstrated virtual collapse of the L5/S1 disc space. There was recurrent left sided disc herniation effacing the left S1 nerve root, displacing this posteriorly and extending into the left L5 nerve root foramen and compromising the left L5 nerve root. The injured worker had an L4/5 disc protrusion without evidence of

neurological impingement. Findings were consistent with collapsed disc space at L5/S1 following discectomy with recurrent neurologic impingement L5 and S1 left. Plain films showed severe L5/S1 disc space narrowing with sclerosis of the endplates. Subjective complaints included on-going debilitating low back and left leg pain that precluded return to work. The physical exam was reported unchanged. The treatment plan included redo lumbar laminectomy L5/S1 bilaterally, and fusion with instrumentation. The 3/11/15 utilization review non-certified the request for L5/S1 lumbar laminectomy and fusion with spinal instrumentation as clinical findings consistent with lumbar radiculopathy documenting motor and sensory deficits were not demonstrated in the recent medical records, and failure of recent conservative treatment with physical therapy was not documented. The 3/14/15 neurosurgical appeal report stated that the injured worker had evidence of instability with collapse of the L5/S1 disc space with marked narrowing and sclerosis with retrolisthesis on MRI. There was facet enlargement, lateral recess encroachment, and foraminal disc protrusion affecting the L5 nerve root on the left and there was posterior displacement of left S1. He had back and leg pain. He had failed prolonged conservative treatment and prior surgical intervention. The injured worker continued to require operative intervention of redo lumbar laminectomy L5/S1 bilaterally and fusion with instrumentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Laminectomy and Fusion with Spinal Instrumentation L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Discectomy/Laminectomy; Fusion (spinal).

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 laminectomy 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. Guidelines state there is no good evidence that spinal fusion alone is 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. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar laminectomy 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 severe function-limiting low back and lower extremity pain. He is status post L5/S1 lumbar laminectomy on 8/14/14. There are no current clinical exam findings documented that evidence radiculopathy and correlate with imaging evidence. There is reported imaging evidence of L5/S1 nerve root compression and lateral recess stenosis. There is no radiographic evidence of spinal segmental instability documented. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. A psychosocial screen was not evidenced. Therefore, this request is not medically necessary at this time.