

Case Number:	CM15-0068760		
Date Assigned:	04/16/2015	Date of Injury:	12/14/2013
Decision Date:	05/20/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/10/2015

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 52-year-old male who sustained an industrial injury on 12/14/13. Injury occurred when he reached for a flashlight and he felt a painful pull in the right lower back. Conservative treatment had included physical therapy, medications, and activity modification. The 4/1/14 electrodiagnostic study impression documented a bilateral abnormal study with EMG findings consistent with chronic motor radiculopathy in multiple myotomes, left worse than right. Nerve conduction study indicated demyelinating process with mixed axonal denervation in the left sural, superficial peroneal sensory and motor nerves consistent with a neuropathic process. The 12/6/14 lumbar spine MRI impression documented slight disc degeneration at L4/5, 2-3 mm degenerative anterolisthesis, and moderate to severe facet arthropathy bilaterally. There were bilateral medial synovial facet cysts that contributed to severe encroachment of the lateral recesses bilaterally, left greater than right, and encroachment of the traversing L5 nerve roots. The 2/13/15 spine surgery report documented focal tenderness at L4/5, L5/S1 and the superior iliac crest, and tenderness along the course of the sciatic notch. There was moderate loss of lumbar range of motion, normal gait, inability to walk on toes due to pain on the right side, and ability to walk on heels with pain bilaterally. There was weakness over the right iliopsoas, quadriceps, and extensor hallucis longus muscles, and weakness over the left anterior tibialis, extensor hallucis longus and gastroc soleus muscles. Patellar reflexes were absent bilaterally. Sensation was decreased over the lateral leg and medial and lateral foot on the right. Straight leg raise and Faber's tests were positive bilaterally. X-rays showed spondylosis of L4/5 and L5/S1. Imaging showed moderately severe lateral recess and foraminal stenosis at L4/5 secondary to

bilateral synovial cysts. Authorization was requested for bilateral laminotomies at L4/5 with resection of the synovial cysts. The 3/20/15 utilization review modified the request for L4/5 facetectomy, synovial cyst removal, and possible fusion and approved L4/5 facetectomy and synovial cyst removal. The rationale for this partial certification indicated that there should be a pre-operative determination of a definitive plan.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 Facetectomy, synovial cyst removal, and possible fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Discectomy.

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 i½ 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. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar laminotomy 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. For any potential fusion surgery, it is recommended that the patient refrain from smoking for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been met for fusion surgery. This patient presents with signs/symptoms and clinical exam findings consistent with imaging evidence of severe lateral recess encroachment and L5 nerve root compression due to large synovial cysts at L4/5. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no radiographic evidence of spinal segmental instability at L4/5. There is no discussion of the need for wide decompression that would result in temporary intraoperative instability. There is no evidence of a psychosocial screen or confirmation of smoking status. The 3/20/15 utilization review partially certified this request for include L4/5 facetectomy and synovial cyst removal without fusion. There is no compelling reason to support the medical necessity of additional surgical procedures at this time. Therefore, this request is not medically necessary.

