MAXIMUS Federal Services

Case Number:	CM15-0071339		
Date Assigned:	04/21/2015	Date of Injury:	09/25/2013
Decision Date:	05/22/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/14/2015

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 54-year-old male who sustained an industrial injury on 9/25/13. The mechanism of injury was not documented. He underwent bilateral L2/3 and left L3/4 hemilaminectomy on 1/13/15. The injured worker presented to the emergency department on 1/26/15 with left groin pain radiating to the medial/anterior left knee. Pain had been increasing since surgery and he had suffered a fall at home with marked aggravation of his pain. There were no bowel or bladder symptoms, or saddle anesthesia. There was left leg weakness, and he sometimes dragged the left leg using a walker. He was in constant pain, using Percocet, morphine and Toradol. A lumbar MRI was performed and IV steroids given. The 1/26/15 lumbar spine MRI impression documented postsurgical changes with fluids extending into the spinal canal and resulting in moderate narrowing of the spinal canal at L2/3 and mild left-sided narrowing at L3/4. Possible infection could not be excluded. The 2/10/15 neurosurgical report indicated the injured worker was not feeling well. He reported that his low back and right leg pain were gone, but he had significant severe left leg pain in an L5 distribution which was different than pre-operative. This pain had been present since very early after surgery. He reported that he leg gave way at times and he had been using a walker or a cane. His wife reported he was taking a lot of pain medications, and had been confused and at time hallucinating. A repeat MRI was ordered to ensure no infection had progressed, although there were no clinical and lab findings indicative of infection. Liver function tests were ordered due to high dose of Tylenol and confusion. The 2/20/15 lumbar MRI impression documented overall improvement in the posterior L2/3 and L3/4 extradural fluid with decreased mass effect on the

thecal sac. There was improvement in fluid and enhancement in the posterior paraspinal musculature extending to the subcutaneous tissues. There was persistent enhancement of the left paraspinal musculature at L5/S1 without evidence of abscess or signal abnormality to suggest myositis. Denervation, possibly postsurgical, related post gadolinium enhancement is a primary consideration. The 2/25/15 treating physician report cited significant pain and marked weakness of the left leg. Despite using a walker or cane, he fell down several times a day. Physical exam documented rather stiff movement with hesitant and broad-based gait. Range of motion was not assessed. Straight leg raise was positive. Deep tendon reflexes were +1 and symmetrical. The injured worker was only taking Oxycodone and was off the Oxycontin and diazepam. The treatment plan indicated review with the neurosurgeon and possible EMG. The 3/18/15 neurosurgical report cited moderate to severe low back pain, slightly improved, but worsened left L3/4 radiculopathy. Pain was severe and leg gave way at times. The treatment plan recommended left L3/4 facetectomy. The 3/30/15 utilization review non-certified the request for left L3/4 facetectomy with decompression and fusion as there was no evidence of segmental instability at L3/4 and the physical exam was not of sufficient detail to allow for clear identification of a left-sided L3/4 radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L3-4 Facetectomy with decompression and fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

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 decompression 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 decompression 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 patient is status post bilateral L2/3 and left L3/4 hemilaminectomy with complaints of severe left L3/4 radicular pain and significant leg weakness resulting in falls. Straight leg raise was positive. There were no

documented clinical neurologic findings correlating with signs/symptoms or with imaging. There was imaging evidence of mild narrowing at L3/4 on the left but no specific nerve root compression. There was no radiographic evidence of spinal segmental instability or discussion of the need for wide decompression resulting in temporary intraoperative instability to support the medical necessity of fusion. There was no evidence of a psychosocial screen. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.