

Case Number:	CM15-0072046		
Date Assigned:	04/22/2015	Date of Injury:	06/20/2010
Decision Date:	05/27/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	04/15/2015

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: Minnesota, Florida
 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 45-year-old female patient who sustained an industrial injury on 06/20/2010. A secondary treating office visit dated 12/17/2014 reported subjective complaints of constant low back pain rated a 6 out of 10 in intensity. She is diagnosed with status post lumbar spine fusion times two 05/20/2013, 08/27/2014. The plan of care involved: prescribing Flexeril, Norco 7.5mg, topical compound cream, and follow up as needed. Diagnostic testing to include, radiography study, magnetic resonance imaging, sleep study, electric nerve conduction study, cardiorespiratory study, and laboratory work up. A primary treating office visit dated 02/06/2015 reported subjective complaint of continued lower back pain with shooting pain down her bilateral lower extremities. The following diagnoses are applied: chronic low back pain; status post lumbar spine fusion; radiculopathy left lower extremity L4 nerve root distribution; cervical strain; degenerative disc disease cervical spine; right shoulder impingement syndrome compensatory from left shoulder, resolve; status post left shoulder arthroscopy; left shoulder tendinitis; status post bilateral upper extremity surgery, rule out gastritis, headaches, hypertension, and depression. She is permanent and stationary. The injured worker is status post two lumbar spine fusion surgeries (5/20/2013 and 8/27/2014). She complains of low back pain radiating down the left lower extremity with numbness and tingling. A neurosurgical consultation of February 17, 2015 indicated excellent position of all the screws without any breakage, loosening or pullout on AP and lateral x-rays. She was having increased pain but the examination findings are not documented. On March 17, 2015, examination revealed the significant limitation of extension to about 10°. The extensor hallucis longus and tibialis anterior

were 4/5 on the left and 5/5 on the right. The gastrocnemius was 4/5 on the left and 5/5 on the right. Sensation was diminished in a left L5 and S1 light touch dermatomal distribution. Reflexes were trace. A CT scan of the lumbar spine dated 3/12/2015 revealed the following impression: 1. bilateral pedicular screws at L4, L5, and S1 with posterior spinal rods. Intact hardware with no peri-hardware lucency or fracture. 2. Bilateral laminectomies at L4-5. 3. At L2-3 moderate disc narrowing and vacuum phenomena. 3 mm posterior disc bulge. Mild narrowing of the central canal. Mild-to-moderate bilateral neural foraminal narrowing. 4. At L3-4-3 millimeter retrolisthesis and 2 mm posterior disc bulge. Mild-to-moderate narrowing of the central canal and severe narrowing of the bilateral recesses. There is possible resultant impingement of the bilateral L4 nerve roots. Moderate bilateral neural foraminal narrowing. 5. At L4-5 posterior margin of the disc is not well evaluated due to metal artifact. Mild bilateral neural foraminal narrowing. 6. At L5-S1 2 mm retrolisthesis. Posterior margin of disc is not well evaluated due to metal artifact. Moderate to severe right and moderate left neural foraminal narrowing. The report does not indicate any hardware failure, loosening, broken hardware, or evidence of a pseudoarthrosis. On March 17, 2015, the provider requested authorization for a presacral approach for L4-S1 interbody screw fixation as well as posterior revision foraminotomy and microdiscectomy bilaterally at L4-5 and L5-S1 levels. Utilization review non-certified the request; however, the utilization review decision or rationale have not been submitted. The adverse decision is now appealed to an independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior Revision Foraminotomy and Microdiscectomy at Bilateral L4-L5 and L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 305, 306.

Decision rationale: California MTUS guidelines indicate surgical considerations for severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, and clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair and failure of conservative treatment to this resolve disabling radicular symptoms. The documentation provided does not indicate any electrophysiologic studies confirming presence of radiculopathy. The CT scan shows evidence of chronic neural foraminal stenosis; however, definite evidence of nerve root compression is not identified. A recent comprehensive non-operative treatment program has not been documented. In the absence of objective evidence of radiculopathy, a repeat decompressive surgery at L4-5 and L5-S1 is not likely to be of benefit. There is no clear clinical, imaging, and electrophysiologic evidence of a lesion that is not medical necessity.

Associated surgical services: Three (3) day in-patient stay: 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.

Presacral Approach for an L4-S1 Interbody Screw Fixation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307, 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion.

Decision rationale: California MTUS guidelines indicate patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials 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 is instability and motion in the segment operated on. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study has shown that only 29% felt much better in the surgical group versus 14% much better in the non-fusion group (a 15% greater chance of being much better) versus a 17% complication rate (including 9% life-threatening or reoperation). The table 12-8 on page 310 indicates spinal fusion is not recommended in the absence of fracture, dislocation, complications of tumor, or infection. The CT scan of the lumbar spine did not show any pseudoarthrosis. The hardware is intact and there is no evidence of loosening or hardware failure documented. The injured worker has undergone fusion twice. A third fusion is not supported by guidelines. The fixation is intact and there is no evidence of instability documented. ODG guidelines for a lumbar fusion indicate all pain generators are identified and treated, all physical medicine and manual therapy interventions are completed, x-rays demonstrating spinal instability and/or myelogram, CT-myelogram or discography and MRI demonstrating disc pathology correlated with symptoms and examination findings and spine pathology limited to 2 levels and psychosocial screen with confounding issues addressed. There is no recent non-operative comprehensive treatment program documented. There is no instability documented. There is no pseudoarthrosis documented and as such, another fusion procedure is not recommended. According to ODG guidelines, a predictor of poor result is the number of prior low back operations. There is no indication if two prior surgical procedures did not help that a third procedure is likely to relieve the continuing pain. As such, the request is not medically necessary.

