

Case Number:	CM15-0078245		
Date Assigned:	04/29/2015	Date of Injury:	07/05/2011
Decision Date:	05/28/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/23/2015

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 70-year-old male who sustained an industrial injury on 7/5/11, relative to a fall. Past surgical history was positive for left shoulder rotator cuff repair on 9/1/11 and right knee arthroscopy on 4/20/12. The 1/12/15 lumbar spine MRI impression documented mild disc degeneration at L4/5 with 2-3 mm broad-based posterior disc protrusion and a 3.5 mm far right posterolateral disc protrusion. There was severe right and moderate left L4/5 facet arthropathy with 2 mm degenerative anterolisthesis of L4 on L5 contributing to severe L4/5 spinal canal stenosis with severe bilateral L4/5 recess stenosis. There was anatomic potential for impingement on the traversing L5 nerves. There was also moderate right and mild left L4/5 foraminal stenosis. At L5/S1, there was a 2-2.5 mm right greater than left posterior disc protrusion without significant neural impingement. There were mild far right and left posterolateral disc protrusions at L2/3 and L3/4 resulting in mild left lateral recess stenosis. The 3/6/15 treating physician report cited a primary complaint of low back pain radiating to left leg. The injured worker had minimal improvement over nearly 4 years despite anti-inflammatories and physical therapy. Physical exam documented full lumbar range of motion with normal strength and deep tendon reflexes. There was decreased left L5 dermatomal sensation. Straight leg raise and Achilles clonus were negative. MRI findings showed L4 to S1 stenosis. The injured worker had radiculopathy refractory to conservative treatment for years. Authorization was requested for L4-S1 decompression and possible fusion and 12 sessions of post op physical therapy. The provider indicated that the decision for fusion would be decided intraoperatively based on whether or not the decompression caused temporary intraoperative instability. The

3/25/15 utilization review non-certified the request for L4-S1 decompression and possible fusion. The rationale noted imaging evidence of significant stenosis at the L4/5 but no clear neurologic abnormalities on the clinical exam or imaging relative to the L5/S1, and no evidence of instability to support the medical necessity of fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 Decompression and Possible Fusion: Upheld

Claims Administrator 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), AMA 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, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The California MTUS guidelines recommend discectomy/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 decompression surgery 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 may be supported for surgically induced segmental instability but pre-operative guidelines recommend completion of all physical medicine and manual therapy interventions and psychosocial screen with all confounding issues addressed. Guideline criteria have not been met. This injured worker presents with persistent low back pain radiating to the left leg, which had failed to improve despite reasonable and/or comprehensive conservative treatment. Clinical exam findings were consistent with imaging evidence of severe lateral recess and canal stenosis with L5 nerve root impingement at the L4/5 level. The treating physician has opined the possible need for fusion due to the potential for temporary intraoperative instability following decompression. However, there is no imaging evidence of significant neural impingement or stenosis at the L5/S1 to support the medical necessity of decompression and possible fusion. Additionally, there is no evidence of a psychosocial screen or clearance to proceed with possible fusion. Therefore, this request is not medically necessary.

Post Operative Physical Therapy (12 sessions for the low back): 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.