

Case Number:	CM15-0078617		
Date Assigned:	04/29/2015	Date of Injury:	06/30/2008
Decision Date:	05/29/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	04/24/2015

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 57-year-old male who sustained an industrial injury on 6/30/08, relative to a heavy lifting. Past surgical history was positive for L4/5 lumbar laminectomy in 1998, followed by complications from a dural tear and revision. Conservative treatment had included activity modification, TENS unit, medications, acupuncture, lumbar epidural steroid injection, and lumbar radiofrequency ablation without sustained improvement. The 12/28/14 lumbar spine MRI impression documented multilevel degenerative disc disease and facet arthrosis. Findings were most pronounced at L2/3 where a 4 mm central disc protrusion combined with bilateral facet arthrosis and grade 1 retrolisthesis producing severe central canal stenosis of 6 mm. The 3/30/15 treating physician report cited low back pain radiating into the right leg. Physical exam documented weakness of the right quadriceps and to a lesser degree the calf, and low back pain with straight leg raising but no sciatic stretch signs as would be expected with the L4/5 distribution sciatica. Sensation was intact. X-rays of the lumbar spine showed L2/3 retrolisthesis and multilevel disc degeneration. Flexion/extension x-rays showed 1-2 mm of motion of the retrolisthesis at the L2/3 level. MRI showed spinal stenosis at L2/3. The diagnosis was L2/3 retrolisthesis, instability, and spinal stenosis. He had failed conservative treatment and surgery was recommended. Authorization was requested for L2/3 transforaminal fusion and decompression. The 4/21/15 utilization review non-certified the request for L2/3 transforaminal lumbar interbody fusion as the reported instability did not meet guideline criteria, there was no details regarding conservative treatment attempted and failure, and prior surgery was noted but the level was not identified. The 4/22/15 treating physician report appeal letter documented prior

surgery history, and indicated that the injured worker had presented earlier this year with right thigh pain consistent with L3 distribution. Exam documented weakness of the quadriceps also consistent with L3. There was stenosis and instability at L2/3.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 L2-L3 transforaminal lumbar interbody fusion: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Fusion.

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. Guidelines state there is no good evidence that spinal fusion alone was 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 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. Spinal instability criteria includes lumbar inter-segmental movement of more than 4.5 mm. 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 presents with low back pain radiating into the right leg. Clinical exam findings were consistent with imaging evidence of plausible nerve root involvement at L2/3. There was a report of 1-2 mm of motion of the retrolisthesis at the L2/3 level. However, guideline spinal instability criteria is motion greater than 4.5 mm. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no evidence of a psychosocial screen or psychological clearance for fusion surgery. Therefore, this request is not medically necessary.