

Case Number:	CM15-0079254		
Date Assigned:	04/30/2015	Date of Injury:	02/14/2013
Decision Date:	05/29/2015	UR Denial Date:	04/08/2015
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 43-year-old male who sustained an industrial injury on 2/14/13. Past medical history was positive for diabetes mellitus. The 7/9/13 lumbar spine MRI impression documented disc desiccation, anterolateral osteophytes, and moderate right sided degenerative facet changes at L5/S1. There was associated moderate narrowing of the L5 neural foramen bilaterally. The 12/12/14 initial spine surgery evaluation report cited a chief complaint of grade 8/10 low back pain. He reported minimal improvement with physical therapy and anti-inflammatories, and temporary relief with epidural injections. Review of systems documented a complaint of depression. Physical exam documented paraspinal muscle tenderness, normal range of motion, normal strength, and 2+ and symmetrical deep tendon reflexes. There was diminished sensation over the bilateral L5 dermatomes. The diagnosis was lumbar radiculopathy. Imaging showed L5 through S1 reduced disc height causing vertical stenosis at the L5 through S1 foramina. The treatment plan recommended L5/S1 decompression and possible fusion. The 4/8/15 utilization review non-certified the request for L5/S1 fusion and associated post-op physical therapy as there was no detailed evidence of conservative treatment, no L5 nerve root compression, no psychosocial evaluation provided, no description of functional limitations or physical impairment, and no indications of progressive neurologic deterioration, myelopathy or spinal instability. The 4/17/15 orthopedic appeal report cited complaints of low back pain radiating to the right leg. There was lumbar paraspinal tenderness to palpation, full lumbar range of motion, and normal lower extremity strength and reflexes. There was decreased sensation over the bilateral L5 dermatomes. The orthopedist stated that he had reviewed the MRI and there was

evidence of nerve compression. He reported decreased disc space height causing foraminal stenosis compressing the L5 nerve roots. The radiologist also reported moderate narrowing of the bilateral foramina at L5 to S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 fusion: 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): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Fusion (spinal).

Decision rationale: The California MTUS guidelines state there was 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. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Guidelines state that spinal fusion is recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. 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 injured worker presents with low back pain radiating down the right leg. Clinical exam findings correlate with plausible imaging evidence of nerve root compression at the L5/S1 level. 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 instability or discussion of the need for wide decompression that would result in temporary intraoperative instability. Additionally, there is documentation suggestive of potential psychological issues with no evidence of psychosocial screening or psychological clearance for surgery. Therefore, this request is not medically necessary.

Post-operative physical therapy 2 times a week for 8 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.