

Case Number:	CM15-0098426		
Date Assigned:	06/03/2015	Date of Injury:	08/09/2013
Decision Date:	07/03/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	05/21/2015

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 was a 53-year-old male who sustained an industrial injury on 8/9/13, relative to heavy lifting. Past medical history was positive for hypertension, hypercholesterolemia, and smoking. The 1/21/14 electrodiagnostic study impression documented findings supportive of chronic right sided L5 nerve root irritation. The 3/19/15 lumbar spine MRI impression documented L4/5 moderate left neuroforaminal stenosis with deformity of the exiting left L4 nerve root. At L5/S1, there were multifactorial degenerative changes, including a left sided synovial cyst resulting in moderate neuroforaminal stenosis and compression on the bilateral exiting L5/S1 nerve root. There was laterally directed disease that mildly effaced the exiting left L2 and bilateral L5 nerve roots and extraforaminal zones. A radiologist addendum on 5/14/15 documented a 3 mm undulating disc bulge at L3/4 slightly asymmetric to the left, and mild to moderate facet arthropathy and ligamentum flavum redundancy. There was mild to moderate lateral recess narrowing causing mass effect on the transiting L4 nerve roots slightly more prominent on the left. Additionally, there was mild to moderate neuroforaminal narrowing deforming the bilateral L3 nerve roots, right greater than left. At L4/5, there was 4 mm undulating disc bulge most prominent in the neural foraminal zones, slightly asymmetric to the left. There was moderate facet arthropathy and ligamentum flavum redundancy. There was mild to moderate lateral recess narrowing with effacement of the transiting L5 nerve roots, left slightly greater than right. Additionally, there was moderate left and mild to moderate right neuroforaminal narrowing with compression of the exiting left and deformity of the exiting right L4 nerve roots. The 3/31/15 treating physician report indicated that the injured worker had lost

20 additional pounds since his last exam; bring his total loss to 80 pounds. Unfortunately, he had grade 8/10 persistent low back and leg pain. He had difficulty with most activities of daily living including prolonged standing, walking, sitting, and bending, twisting and lifting. Conservative treatment had not improved his symptoms. Physical exam documented significant forward lean posture, right greater than left paraspinal muscle tenderness, and antalgic gait to toe and heel walking on the right. Straight leg raise was positive at 60 degrees right and 70 degrees left. There were 4+/5 right extensor hallucis longus weakness, decreased right L5 dermatomal sensation, and absent Achilles reflexes bilaterally. MRI findings were essentially unchanged and showed degenerative disc disease at L3/4, L4/5 and L5/S1 with facet arthropathy, lateral recess and foraminal stenosis right greater than left. Authorization was requested for lumbar decompression and fusion from L3 to S1. The 4/28/15 treating physician reconsideration request indicated that the injured worker had exhausted all conservative treatment, including physical therapy, pain management, and epidural steroid injections with continued low back and leg pain. Symptoms were significantly impacting his activities of daily living. Imaging findings were reviewed and reconsideration of the request for decompression and fusion from L3 to S1 was requested. The injured worker would require a complete laminectomy and facetectomy to address the stenosis which will create an iatrogenic instability from L3 to S1. The 5/12/15 treating physician report cited severe grade 7/10 lower back and bilateral leg pain. Pain increased with bending, stooping or squatting. He reported sleep difficulty due to pain. Current body mass index was 29. Physical exam documented forward lean posture wearing a back brace. There was lumbosacral tenderness to palpation and limited range of motion with tenderness. There was ¾ inch atrophy in the right quadriceps. Neurologic exam documented 5/5 lower extremity motor strength and sensory impairment in the L4 and L5 dermatomal distributions bilaterally. Authorization was again requested for lumbar decompression and fusion L3-S1. The 5/13/15 utilization review non-certified the lumbar decompression and fusion and associated surgical requests as there was limited documentation of spinal instability or significant foraminal stenosis with disc collapse requiring wide decompression with destabilization, no evidence at nerve root compression at all 3 levels or severe central canal stenosis with symptoms of neurogenic claudication to indicate the need for decompressive laminectomy from L3 to S1, and no evidence of a complete recent motor, sensory and reflex exam of both lower extremities to justify 3-level decompression. The peer-to-peer discussion documented that the injured worker had quit smoking over the past 6 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar laminectomy L3-S1, Posterior spinal fusion L3-S1 with pedicle screw fixation, transforaminal lumbar interbody fusion with interbody cages L3-S1 with bone graft extenders, bone marrow aspiration: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery-Discectomy/laminectomy.

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 ½ Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The California MTUS guidelines recommend laminotomy, laminectomy, and discectomy 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. For any potential fusion surgery, it is recommended that the patient refrain from smoking for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been met. This injured worker presents with persistent and function-limiting low back and lower extremity pain. Clinical exam findings have been consistent with imaging evidence of nerve root compression at the L3/4, L4/5, and L5/S1 levels. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is no radiographic evidence of spinal segmental instability. The treating physician has opined the need for wide decompression resulting in temporary intraoperative instability. Smoking cessation has been reported. However, there is no evidence of psychosocial screening. Therefore, this request is not medically necessary at this time.

Four day inpatient hospital stay: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back ½ Lumbar & Thoracic: Hospital length of stay (LOS).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Assistant surgeon: 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.