

<b>Case Number:</b>	CM13-0060118		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	06/07/2013
<b>Decision Date:</b>	05/29/2014	<b>UR Denial Date:</b>	11/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 38 year old male who was injured on 06/07/2013. He was in the process of lifting and twisting while he was picking up products. He felt a sudden pinch in his low back. After that occurred, he started having low back pain and that is when he re-aggravated it severe weeks later. Prior treatment history has included Norco and OxyContin. There is no documentation of any rehabilitative treatment. Urine drug screen dated 10/30/2013 tested positive for hydrocodone and hydromorphone. Diagnostic studies reviewed include MRI of the lumbar spine dated 09/12/2013 demonstrates spondylosis at L5-S1; L4-5 shows a 2-3 mm posterior disc bulge resulting in moderate to severe right and moderate left neural foraminal narrowing in conjunction with mild facet joint hypertrophy; Bilateral exiting nerve root compromise is seen. There is a 2-3 mm posterior disc bulge at L5-S1 resulting in moderate bilateral neural foraminal narrowing; and bilateral exiting nerve root compromise is seen. PR2 dated 12/16/2013 reports the patient complains of low back pain and he has been unable to work for about the past 4 weeks now because of the increase in pain. The pain radiates down to the lower extremity, on the left side in particular. There is a significant amount of discomfort and pain. He rated his pain at 7-8/10. He denies any numbness and tingling to that extremity. He is wearing a back brace. The patient is requesting a refill of Norco, which he takes about 6 pills a day and OxyContin which he takes 3 pills a day. On exam, he is unable to walk effectively, as well as bend forward farther than about 15 degrees to 20 degrees and extension is about 5 degrees. The muscles are very tender on palpation to the lumbosacral region. He is unable to do a heel-toe walk because of the discomfort and weakness. The deep tendon reflexes are a bit more brisk on the left side in the lower extremities when compared to the right side. There is right sensory deprivation and some symptoms of pain that radiates down what appears to be more like an S1 dermatome that goes through the heel into the plantar fascia which would be

more of that as opposed to laterally. Diagnosis is discopathy in an L5-S1 distribution. Orthopedic office note dated 10/31/2013 reports the patient presents with low back pain and bilateral lower extremity radiculopathy. He has been on heavy narcotics for at least 6 years. His pain is in the back and radiates down into both legs. In the past, he has tried physical therapy and conservation measures, which have not helped. The low back pain radiates down into both legs. At first, it started mostly down the right leg and more recently it has now come down into both legs. There have been recent changes in bladder habits and he reports he is having difficulty in his sex life. Sensory examination shows no areas of diminished perception to pinprick or soft touch in the lower extremities. Assessment is the patient has subjective instability, mechanic back pain, discogenic in nature; and he has failed extensive conservative care. The plan is a L4 to S1 instrumented fusion and decompression.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **IP LUMBAR DECOMPRESSION FUSION L4-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:** According to the CA MTUS guidelines, surgical consideration of low back complaints is indicated for: Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), 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, 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, Failure of conservative treatment to resolve disabling radicular symptoms. The medical records document the patient had complained of low diagnosed with discopathy with an L5 and S1 dermatomal distribution. In the absence of documented electrophysiologic evidence of a lesion and absence of conservative treatment trials, the request is not medically necessary according to the guidelines.