

<b>Case Number:</b>	CM13-0068040		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	02/08/2010
<b>Decision Date:</b>	05/30/2014	<b>UR Denial Date:</b>	12/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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, has a subspecialty in Spine Surgery and is licensed to practice in Texas and 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 injured worker is a 52-year-old female who reported an injury on 02/08/2010 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her cervical spine and lumbar spine. The injured worker's treatment history included L5-S1 fusion. The injured worker underwent an MRI of the lumbar spine dated 09/18/2013 that documented there was a solid anterior fusion at the L5-S1 with an interforaminal osteophyte formation resulting in moderate degree of bilateral foraminal stenosis. The injured worker was evaluated on 09/18/2013. Evaluation of the lumbar spine documented tenderness over the spinous process from the L4 to the S1 with 3+ spasming noted within the paraspinal musculature. The injured worker had reduced range of motion secondary to pain with a positive right side straight leg raise test and 4+/5 motor strength of the extensor hallucis longus of the right side with absent Achilles reflexes bilaterally. It was noted that the injured worker had decreased sensation to light touch and pinprick over the L5 dermatome distribution. Surgical intervention due to a collapsed fusion pars defects was recommended. A supplemental report for a review of a denial letter was provided on 11/06/2013. It was documented that the request for the lumbosacral discectomy, laminectomy, and decompression with pedicle screws at the L5-S1 was not authorized. It was documented that the injured worker had failed conservative treatment with a grade 1 spondylothesis at the L5-S1 and the injured worker has ongoing radicular complaints.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **LUMBOSACRAL FACECTOMY, LAMINECTOMY AND DECOMPRESSION WITH PEDICALE SCREWS AT L5-S1 BILATERALLY: 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

**Decision rationale:** The requested lumbosacral facectomy, laminectomy and decompression with pedicle screws at L5-S1 bilaterally is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends surgical intervention for severe disabling symptoms that would benefit from surgical intervention and are corroborated by an imaging study. The clinical documentation submitted for review does include a CT of the lumbar spine. It was documented that the injured worker had a solid anterior fusion with evidence of an old pars defect and very mild anterolisthesis in combination with moderate degree of bilateral frame stenosis. Clinical documentation submitted for review does indicate that the injured worker has radicular symptoms consistent with the L5-S1 dermatomal distribution. However, the clinical documentation fails to identify a significant change in the injured worker's pathology that would support additional surgical intervention. Clinical documentation does not support the fusion surgery at the L5-S1. The clinical documentation did not provide a significant change in the injured worker's clinical presentation that would support a change in pathology that would require surgical intervention. As such, the lumbosacral facectomy, laminectomy and decompression with pedicle screws at L5-S1 bilaterally is not medically necessary or appropriate.