

<b>Case Number:</b>	CM14-0100384		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	04/18/2013
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	06/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 Spine Surgeon and is licensed to practice in Texas. 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 32-year-old female who reported an injury on 04/18/2013. The mechanism of injury was the injured worker was walking to a fax machine room when she stepped on a strap with her right foot, her left foot went under the strap which caused her to trip. To avoid falling, the injured worker jumped and freed her foot from the strap and landed on her feet jarring her low back. The injured worker's prior therapies included physical therapy, a trail of acupuncture and acupressure and epidural steroid injections. Diagnoses included cervical thoracic strain with resultant cephalgia, left shoulder misdirectional instability, lumbosacral strain and herniated nucleus pulposus at L5-S1 as well as status post left foot/ankle sprain and strain. The injured worker's medications were noted to include Tylenol, diclofenac, Prilosec, and Zanaflex. The injured worker underwent an MRI of the lumbar spine without contrast on 4/22/2013 that revealed at the level of L5-S1 there was a posterior and left lateral disc protrusion measuring 8.1 mm with 5.1 mm of inferior disc migration. The left sided S1 nerve root was displaced and slight compressed against the facet. There was mild right foraminal, mild to moderate central canal and moderate left lateral recess and mild left neural foraminal narrowing. The documentation indicated the injured worker had previously been approved for a laminectomy and discectomy. The levels were not provided. The injured worker underwent x-rays on 06/12/2014 which revealed the injured worker had a retrolisthesis at L5-S1 with motion on flexion and extension x-rays. The subjective complaints were of low back pain with associated numbness and tingling in the bilateral lower extremities, worse on the left. The injured worker was noted to be utilizing a low back support with relief. The physical examination revealed the injured worker had tenderness to light touch of the lumbar paravertebral musculature. The injured worker had decreased range of motion. The injured worker had a positive straight leg raise test and Braggard's test bilaterally. The injured worker's

strength was 4/5 in the right EHL and gastroc/peroneus longus and in the left was 3/5 in the EHL and 2/5 in the gastroc/peroneus longus. The deep tendon reflexes were 1+ in the Achilles and 2+ in the patella tendon. The sensory examination of the lower extremities was decreased to light touch at L5-S1 in the dorsum of the foot. The physician documented for the MRI of the lumbar spine, the injured worker had a transitional vertebra and the last motion segment would be named L5-S1. The rudimentary disc would be named S1-S2. The review of the MRI's were noted to be consistent with very large extruded and sequestered disc fragment at L5-S1 with disc fragments extending into the neural foramina bilaterally at L5-S1. There was disc height collapse at L5-S1. The diagnoses included L5-S1 retrolisthesis with instability with a large extruded and sequestered disc fragment extending into the neural foramina at L5-S1 and extending caudally to S1-S2 and bilateral lower extremity radiculopathy with numbness and pain. The treatment plan and discussion included as the injured worker had failed physical therapy, anti-inflammatories and epidural steroid injections and had severe pain and bilateral lower extremity radicular pain with x-rays that were consistent with the retrolisthesis at L5-S1 and a large sequestered disc fragment with extension into the neural foramina, the injured worker should have an anterior lumbar interbody fusion at L5-S1 followed by a posterior decompression and discectomy. There was a Request for Authorization submitted for review.

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

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

**Lumbar spinal fusion:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308. Decision based on Non-MTUS Citation Official Disability Guidelines, treatment Index, Low Back

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and 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 and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Electrophysiologic evidence would not be necessary to support a fusion. The clinical documentation submitted for review indicated the injured worker had failed conservative care. The physician documented that the injured worker had x-rays which revealed retrolisthesis of L5-S1 with motion on flexion and extension x-rays. There was a lack of documentation indicating the injured worker had lumbar intersegmental movement of more the 4.5 mm. The

request as submitted failed to indicate the level of spinal fusion. The MRI findings were at the level of L5-S1 and the Request for Authorization was at the level of L5-S1. Given the above and the lack of clarity, the request for Lumbar spinal fusion is not medically necessary.