

<b>Case Number:</b>	CM14-0122618		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	12/06/1998
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/04/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

Patient is a 62-year-old female who has submitted a claim for lumbar central stenosis with disc collapse associated with an industrial injury date of 12/06/1998. Medical records from 2013 to 2014 were reviewed. Patient complained of low back pain radiating to bilateral lower extremities. Aggravating factors included prolonged sitting, standing, bending, stooping, and lifting. Alleviating factors included rest, intake of medications, and electrical stimulation. Patient smokes 15 cigarettes per day. Physical examination showed tenderness at the paralumbar muscles, lumbosacral junction and bilateral sciatic notches. Range of motion of the lumbar spine was restricted. Straight leg raise test was positive bilaterally. Areflexia was noted at bilateral Achilles. Motor strength of left great toe extensor and left foot evertor was graded 4/5. Sensation was diminished at bilateral L4 to S1 dermatomes. MRI of the lumbar spine, dated 12/16/2013, demonstrated multilevel disc degeneration at L3-L4 through L5-S1, most pronounced at L4-L5. A 3 to 3.5 mm broad-based posterior disc protrusion at L3-L4 contributes to moderate L3-L4 spinal canal stenosis with moderate left and mild to moderate right L3-L4 lateral recess stenosis. Treatment to date has included chiropractic care, lumbar epidural steroid injections, acupuncture, physical therapy, home exercise program, EMS, and medications. Utilization review from 08/12/2014 denied the request for TLIF at L3-L4 to L5-S1 laminectomy with inter body fusion with pedicle screw fixation because there was insufficient information in the records provided regarding recent non-operative treatment and symptoms of neurogenic claudication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TLIF at L3-L4 to L5-S1 laminectomy with interbody fusion with pedicle screw fixation:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines, low back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, page 127. Official Disability Guidelines (ODG) Low Back Section, Fusion (spinal).

**Decision rationale:** Pages 305 - 307 of CA MTUS ACOEM Guidelines state that lumbar surgical intervention is recommended for patients who have: severe lower leg symptoms in the distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise; activity limitations for more than one month; clear imaging of a lesion; and failure of conservative treatment to resolve disabling radicular symptoms. In addition, ODG states that pre-operative surgical indication recommendation for lumbar fusion should include all of the following: (1) all pain generators identified, (2) all physical medicine completed, (3) imaging studies to support level of operation, (4) spine pathology limited to two levels, (5) psychosocial screen, and (6) patient should refrain from smoking for at least 6 weeks prior to surgery. In this case, patient complained of low back pain radiating to bilateral lower extremities. Physical examination of the lumbar spine showed tenderness and restricted range of motion. Straight leg raise test was positive bilaterally. Areflexia was noted at bilateral Achilles. Motor strength of left great toe extensor and left foot evertor was graded 4/5. Sensation was diminished at bilateral L4 to S1 dermatomes. MRI of the lumbar spine, dated 12/16/2013, demonstrated multilevel disc degeneration at L3-L4 through L5-S1, most pronounced at L4-L5. A 3 to 3.5 mm broad-based posterior disc protrusion at L3-L4 contributes to moderate L3-L4 spinal canal stenosis with moderate left and mild to moderate right L3-L4 lateral recess stenosis. Patient's symptoms persisted despite conservative management involving chiropractic care, lumbar epidural steroid injections, acupuncture, physical therapy, home exercise program, EMS, and medications. However, there was no discussion as to why a three-level fusion was necessary when the guideline recommends that surgery is indicated for spine pathology limited to two levels. Moreover, progress report from 04/23/2014 cited that patient smokes 15 cigarettes per day. However, there was no evidence that patient was advised to discontinue smoking to limit the risk of fusion failure. The medical necessity cannot be established due to insufficient information. Therefore, the request for TLIF at L3-L4 to L5-S1 laminectomy with inter body fusion with pedicle screw fixation is not medically necessary.