

<b>Case Number:</b>	CM14-0175176		
<b>Date Assigned:</b>	10/28/2014	<b>Date of Injury:</b>	09/10/2013
<b>Decision Date:</b>	12/04/2014	<b>UR Denial Date:</b>	10/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2014

### 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 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:

This is a 29 year old male with a 9/10/13 injury date. He injured his lower back while pulling a whacker plate out of a hole. In an 8/22/14 follow-up, subjective complaints included lower back pain with radiation to the right leg, and numbness in the posterior distal lateral right leg. Objective findings included tenderness over the paralumbar muscles, limited lumbar range of motion, positive sitting straight leg raise on the right, painful heel/toe walk, decreased sensation in the right L5 distribution, and normal motor/reflex exams. An 8/8/14 lumbar MRI showed an L4-5 disc herniation that compresses that transitioning right L5 nerve root. An 8/8/14 lumbar CT showed L5 pars defects with grade I anterolisthesis of L5 on S1. The surgical provider recommended a right L4-5 microdiscectomy. However, the surgeon indicated that, because of the L5 pars defect, he would need to perform a partial facetectomy at right L4-5 in order to get lateral enough to keep the L5 nerve root safe. This may destabilize his pars defect and cause the need for a fusion early on. Diagnostic impression: L4-5 disc herniation, L5-S1 spondylolisthesis, bilateral L5 pars defects.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Discectomy for Right L4-L5 with fusion if needed:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation (ODG): Low Back Chapter-- Decompression, Fusion.

**Decision rationale:** CA MTUS states that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the 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; and failure of conservative treatment. In addition, CA MTUS states that 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. In this case, there is objective sensory dysfunction in the right L5 dermatome that correlates with the right L5 nerve compression seen on MRI. Although it would strengthen the case if there were objective motor or reflex deficits on exam, there is a positive straight leg raise on the right side and the sensory loss correlates precisely with the lesion on MRI. In addition, the patient has failed all the appropriate conservative treatment measures, including epidural steroid injection and physical therapy. The presence of bilateral L5 pars defects complicates matters somewhat, in that there is an increased risk of iatrogenic instability that would require spinal fusion. However, the provider has recognized this risk and has indicated that he would be prepared to fuse the spine at that level if necessary. Therefore, the request for Discectomy for Right L4-L5 with fusion if needed is medically necessary.