

<b>Case Number:</b>	CM14-0181988		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	10/29/2013
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	09/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2014

### 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 Surgery, 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 56-year-old female who reported an injury on 10/29/2013. The injured worker underwent an MRI of the lumbar spine on 12/26/2012 which revealed a L3-4 and L4-5 there was spinal stenosis. There was moderate narrowing of the central canal. There tiny central disc protrusion at L5-S1. The mechanism of injury was lifting. Prior treatments included medications and physical therapy. The injured worker underwent a left L4-5 facet block on 01/24/2014. The documentation of 08/21/2014 revealed the injured worker had received 1 epidural steroid injection which was "not a lot of benefit." The injured worker was noted to have continual pain in her low back, predominantly on the left side, with radiating pain into the bilateral buttocks and down her left leg. Symptoms were noted to be nearly constant. The surgical history was noncontributory. The medications included multivitamins. The injured worker was noted not to smoke. The physician's documentation indicated the injured worker underwent an MRI of the lumbar spine on 01/03/2014 with a marked ligamentum flavum hypertrophy at L4-5 with grade 1 spondylolisthesis. There was a synovial cyst emanating from the left facet joint impinging the left L5 nerve root. There was broad based disc bulging at L5-S1, without canal stenosis. At L3-4, there was no significant canal narrowing and mild foraminal narrowing. The injured worker noted to have undergone a subsequent MRI on 06/27/2014 which revealed moderate canal stenosis at L3-4 without foraminal narrowing. At L4-5, there was moderate to severe stenosis and mild foraminal narrowing. The injured worker had a myelogram on 06/27/2014 which revealed a grade 1 spondylolisthesis at L4-5. The physical examination revealed the injured worker was in no acute distress. The injured worker ambulated on her heels and toes with a slightly left antalgic gait. The injured worker had a little difficulty in heel walking on the left. The injured worker had a slight step off deformity and tenderness to the lower lumbar area. The active range of motion was limited in the thoracolumbar spine. Straight

leg raise was moderately positive on the left and negative on the right. The injured worker had definite weakness to 1 to 2 grades out of 5 in the left ankle dorsiflexors and left EHL. There was diminished sensation at the dorsum of the left foot. The left quad reflexes were mildly diminished compared to the right. Achilles reflexes were 0 to 1+. The injured worker was noted to have undergone flexion/extension roentgenographic studies, where the injured worker was found to have spondylolisthesis of L4 on L5, estimated to have 9 mm of gross motion. The physician indicated there was no spondylolisthesis at L3-4. The diagnoses included history of lumbosacral strain, spondylolisthesis of L4 on L5, mild to slight stenosis at L3-4, severe stenosis at L4-5 with a synovial cyst on the left, persistence of back and left radicular pain, and trace neurological deficits secondary to the above. The treatment plan included anterior retroperitoneal discectomies, open reduction of the spondylolisthesis, and stabilization at L4-5. The physician documented that there was no indication to perform a fusion at L3-4, as there was no instability. This would be followed with a lumbar laminectomy at L4-5 to decompress the cauda equina nerve root. There was no 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:

#### **1 Anterior lumbar discectomy and segmental fusion L3-L4, L4-L5 and laminectomy and medial facetectomy at the L3, L4, L5 levels: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chapter: Low Back - Lumbar & Thoracic

**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 indicates a surgical consultation may be appropriate for an injured worker who has 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. There should be documentation of 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. There were objective findings to support the requested level of surgery, with the exception of findings to support a necessity for surgical intervention at L3 and L4. The clinical documentation submitted for review failed to provide documentation of electrodiagnostic studies. There was a lack of documentation of a failure of conservative care. However, there was a lack of documentation of the official MRI and myelogram results to support nerve impingement. There was a lack of documentation indicating the necessity for medial facetectomy at L3, L4, and L5. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for 1 anterior lumbar discectomy and segmental fusion L3-L4, L4-L5 and laminectomy and medial facetectomy at the L3, L4, L5 levels is not medically necessary.

**1 LSO (lumbo-sacral orthosis) jacket: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**1 Co-surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.