Case Number:	CM14-0073617		
Date Assigned:	07/16/2014	**Date of Injury:**	09/03/2008
Decision Date:	10/22/2014	**UR Denial Date:**	05/09/2014
Priority:	Standard	**Application Received:**	05/20/2014

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 47-year-old male who reported an injury on 09/03/2008. The mechanism of injury was a fall. The medications were not provided. The injured worker had a right knee arthroscopy in 2009. Conservative treatment included physical therapy, acupuncture, chiropractic care, and epidural steroid injections. The injured worker underwent a psychological evaluation on 02/18/2014. The injured worker's diagnoses included major depression recurrent and severe without psychotic features, somatization disorder, and adjustment disorder with anxiety. The documentation of 03/31/2014 revealed the injured worker underwent multiple surgical procedures for his right knee and right ankle. The injured worker had persistent low back pain and the MRI revealed disc abnormalities. It was further documented the injured worker underwent an evaluation regarding ongoing orthopedic complaints, and was diagnosed with acute lumbar strain with multilevel stenosis, right knee meniscal tear, status post arthroscopy, right ankle ligamentous injury status post reconstruction, and nonorthopedic injuries. The recommendation was a neurosurgical spine consultation. The injured worker had complaints of ongoing pain in the low back with radiation to the bilateral lower extremities, left greater than right. The injured worker indicated he had symptoms including pins and needles in the lower extremities. The specific medications were not provided. The injured worker was a nonsmoker. The injured worker had x-rays on 03/28/2014, which revealed disc degenerative with a collapse at L4-5 and L5-S1, with bilateral neural foraminal narrowing and disc height loss. There was a 2 mm retrolisthesis at L4-5 and L5-S1 with extension, which translated to approximately 1 mm of anterolisthesis with flexion for a total of 3 mm translation at L4-5 and L5-S1. The treatment included an L4-5 and L5-S1 transforaminal and posterior fusion, laminectomy, and decompression. The objective physical findings revealed the injured worker had diffuse tenderness and spasms. The straight leg raise was positive at 50 degrees on the right

and 45 degrees on the left. There was decreased sensation in the bilateral lateral and posterior calves. The deep tendon reflexes were 2+ in the knees and 1+ in the ankles in the Achilles bilaterally. There was 4/5 strength in the EHL and gastrocs bilaterally. The physician documented the injured worker's MRI on 10/17/2013 revealed congenital spinal stenosis due to short pedicles from L3 through L5. There was a disc bulge with a 4 mm posterior right paracentral and right foraminal disc protrusion at L2-L3 with resultant mild spinal stenosis, as well mild to moderate right neural foraminal narrowing. There was a disc bulge with a 3 to 4 mm posterior disc protrusion at L4-L5, which together with mild facet arthropathy and short pedicles resulted in acquired and congenital mild spinal stenosis as well as moderate bilateral neural foraminal narrowing. The disc protrusion abutted the bilateral L5 nerve roots, which may cause mass effect. There was a disc bulge with a 3 mm posterior disc protrusion at L5-S1, which together with moderate facet arthropathy resulted in mild to moderate bilateral neural foraminal narrowing. There was no evidence of spinal stenosis at this level. However, the disc protrusion was noted to abut and cause mild mass effect on the S1 nerve root. There was mild disc height loss at L3-4 and L4-5. The diagnoses included congenital spine stenosis and disc bulging. There was a detailed 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:

Inpatient L4-L5 & L5-S1 Laminectomy/Decompression, L4-5, L4-S1 Transforaminal and Posterior Fusion w/Pedicle Screws & Bone Graft.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

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. Clinicians should consider referral for psychological screening to improve surgical outcomes. The clinical documentation submitted for review indicated the injured worker had objective findings upon physical examination. There was a lack of documentation indicating nerve conduction studies to support nerve impingement. The x-rays indicated the injured worker had a 3 mm translation of anterolisthesis and retrolisthesis at L4-5 and L5-S1. To support surgical intervention, there should be documentation of a relative angular motion greater than 20 degrees,

and for significant instability, there should be documentation of greater than 4.5 mm of translation between flexion and extension radiographs. The official MRI was not provided for review. There was documentation the injured worker had a failure of conservative care. There was a lack of documentation indicating the injured worker had findings of nerve root impingement at the level of L4-5. There were no electrodiagnostic studies provided with the supplied documentation. There was a lack of documentation indicating the injured worker had been cleared psychologically for surgical intervention. Given the above, the request for Inpatient L4-L5 & L5-S1 Laminectomy/Decompression, L4-5, L4-S1 Transforaminal and Posterior Fusion w/Pedicle Screws & Bone Graft is not medically necessary.