Case Number:	CM14-0172115		
Date Assigned:	10/23/2014	**Date of Injury:**	10/02/2013
Decision Date:	02/28/2015	**UR Denial Date:**	09/17/2014
Priority:	Standard	**Application Received:**	10/17/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Texas
Certification(s)/Specialty: Orthopedic Surgery

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 51-year-old male who reported injury on 10/02/2013. The mechanism of injury was the injured worker stepped off of a rail, acutely injuring his low back after a fall. Prior treatments included medication management, physical therapy, work restrictions, modifications, and a TENS unit. Prior surgeries were stated to be none. The documentation of 08/26/2014 revealed the injured worker was extremely disabled by pain. The injured worker had posterolateral radicular pain down his left leg almost continually. The injured worker was unable to stand or walk more than a few minutes. The injured worker had to lie down or sit approximately 12 hours per day. The distance tolerance was 1 half of a block. The injured worker had difficulty getting up on the examination table due to advanced severe lumbar spine pain. The physician documented the injured worker had no epidural steroid injections, although they had been requested and denied. The injured worker's medications included Norco 10/325 mg, tramadol 50 mg and baclofen 10 mg. The physical examination revealed the injured worker could flex to 30 degrees. The injured worker had palpable severe paraspinal muscle spasms. The injured worker extended to +10 degrees with a great deal of back pain. The straight leg raise was positive at 80 degrees on the left. The injured worker had absent posterior tibial pulses, and 2+ dorsalis pedis pulses. The injured worker had 5/5 strength in the legs. The reflexes were 2+ at the patella and the ankle areas. The injured worker had some give way loss of strength in the left toe and foot extensors. The injured worker had diminished pinprick in the L5 and S1 nerve root distributions on the left side going up the side of his leg in a radicular distribution. The physician further documented the injured worker had an EMG and nerve conduction study on

04/14/2014, which revealed paraspinous muscle denervation and EMG findings that were consistent with left lower extremity radiculopathy. The injured worker had an MRI on 10/18/2013, which revealed advanced degenerative disc disease, primarily at L4-5 and L5-S1 with narrowing of the left sided neural foramina. The injured worker had facet hypertrophy with moderate left, severe left and mild right foramina narrowing at L4-5 and L5-S1. At L4-5, there was moderate left and mild right neural foraminal narrowing consistent with symptoms. The treatment plan included a lumbar decompression and fusion. It would be a lumbar decompression and facetectomy on the left side, cage placement and pedicle screw fusion. A total facetectomy would be necessary bilaterally to decompress the injured worker and would not help the pain but would aggravate it. The only surgical procedure the physician opined to be appropriate would be a 2 level pedicle screw fusion, interbody cage placement from the left side and transverse process fusion with autologous bone and infused bone morphogenic protein. The injured worker was noted to be a smoker, and the physician documented the injured worker would have to stop smoking if he wanted the operation. The injured worker stated he was willing to do so. 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:

Two level pedicle screw fusion, facetectomy on the left, placement of interbody cages, and nerve root decompression: Upheld

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

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. The clinical documentation submitted for review indicated the injured worker had objective findings and had failed conservative care. However, there was no official electrodiagnostic or MRI evidence to support the requested intervention. The physician documentation indicated the surgical intervention was for L5-S1 and L4-5. The request as submitted failed to indicate the level. Given the above, the request for two level pedicle screw fusion, facetectomy on the left, placement of interbody cages, and nerve root decompression is not medically necessary.