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| <b>Case Number:</b>   | CM15-0005044 |                              |            |
| <b>Date Assigned:</b> | 02/18/2015   | <b>Date of Injury:</b>       | 11/27/1996 |
| <b>Decision Date:</b> | 04/17/2015   | <b>UR Denial Date:</b>       | 12/19/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/09/2015 |

### 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: Oregon, California

Certification(s)/Specialty: Neurological 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 57-year-old female who reported an injury on 11/27/1996. The mechanism of injury involved a fall. The current diagnoses include status post left carpal tunnel release, severe facet arthropathy, grade 1 spondylolisthesis, status post permanent spinal cord stimulator placement, lumbar stenosis, left L5 radiculopathy, status post lumbar decompression in 2009, lumbar disc degeneration, status post left total knee arthroplasty, and status post removal of spinal cord stimulator in 2014. The injured worker presented on 12/09/2014 for a follow-up evaluation with complaints of low back and buttock pain radiating down the left lower extremity, causing numbness from the shin and calf area into the foot. Upon examination, the injured worker utilized a motorized chair due to severe difficulty with walking short distances. There was tenderness to palpation noted, as well as paresthesia in the left L4 and L5 dermatomal distribution. Range of motion was documented at 38 degree flexion, 6 degree extension, 14 degree left lateral bending, and 12 degree right lateral bending. There were absent Achilles reflexes bilaterally, absent patellar reflex on the left, and diminished motor strength in the left lower extremity. Straight leg raise test was positive on the left and negative on the right. Recommendations at that time included an anterior lumbar interbody fusion at L5-S1. A Request for Authorization form was then submitted on 12/09/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 Anterior Lumbar Interbody Fusion with Cage and Instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (spinal).

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. In this case, there was no documentation of a recent attempt at any conservative management. There was no evidence of spinal instability upon flexion and extension view radiographs. There was no documentation of a psychosocial screening. Given the above, the request is not medically appropriate at this time.

**Posterior Spinal Instrumentation and Fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (spinal).

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. In this case, there was no documentation of a recent attempt at any conservative management. There was no evidence of spinal instability upon flexion and extension view radiographs. There was no documentation of a psychosocial screening. Given the above, the request is not medically appropriate at this time.

**Left L5-S1 Laminotomy and Facetectomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back

Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Discectomy/Laminectomy.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines recommend a lumbar discectomy/laminectomy when there is objective evidence of radiculopathy upon examination. Imaging studies should reveal nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment should include activity modification, drug therapy, epidural steroid injections, physical therapy, or manual therapy. In this case, there were no imaging studies provided for this review. There was no documentation of a recent attempt at any conservative management. Given the above, the request is not medically appropriate at this time.

**Length of Stay 3 Days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** As the injured worker's surgical procedure has not been authorized, the associated request is not medically necessary.

**Assistant 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:** As the injured worker's surgical procedure has not been authorized, the associated request is not medically necessary.

**Vascular 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:** As the injured worker's surgical procedure has not been authorized, the associated request is not medically necessary.