

<b>Case Number:</b>	CM15-0100615		
<b>Date Assigned:</b>	06/02/2015	<b>Date of Injury:</b>	03/06/2014
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	04/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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: Illinois, California, 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 42-year-old female who sustained an industrial injury on 3/6/2014, relative to continuous trauma as an apparel inspector. Past medical history was negative. She was a non-smoker. The 7/24/14 lumbar spine MRI impression documented disc desiccation at L5/S1. At L4/5, there was a focal central disc protrusion indenting the thecal sac. The L4 exiting nerve roots were unremarkable. At L5/S1, there was a diffuse disc protrusion with effacement of the thecal sac and compromise of the spinal canal and bilateral lateral recess narrowing. There was disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaced the bilateral L5 exiting nerve roots, left greater than right. Conservative treatment included medications, physical therapy, chiropractic, epidural steroid injections, and activity modification. The 1/7/15 bilateral lower extremity EMG/NCV revealed an acute left L5 radiculopathy. The 4/3/15 treating physician report cited persistent low back pain radiating into the left lower extremity. The injured worker had minimal improvement with anti-inflammatories and physical therapy, and only a few days relief with the last epidural injection. The lumbar spine exam documented lumbar paraspinal tenderness, full range of motion, 5/5 lower extremity motor strength, normal deep tendon reflexes, negative straight leg raise, and negative clonus. There was diminished left L5 dermatomal sensation. Imaging showed L4 to S1 disc protrusion. The diagnosis was lumbar stenosis. The treatment plan recommended L4 to S1 decompression and possible fusion. The treating physician report opined that fusion may be necessary if iatrogenic instability was created by removal of more than 50% of the facets. Records indicated that a lumbar epidural steroid injection was performed on 4/13/15 with follow-up scheduled in May.

The 4/16/15 utilization review non-certified the requests for L4/5 and L5/S1 decompression and possible fusion as there was no documentation of response to the most recent conservative treatment. Additionally, the imaging findings did not support the need for wide decompression or possible lumbar fusion at this time. The 4/17/15 treating physician appeal report stated that the injured worker had a few hours of relief following the epidural steroid injection on 4/13/15. Clinical exam findings were unchanged. Imaging showed L5 to S1 disc herniation and desiccation. The injured worker was a candidate for L5 to S1 decompression and fusion.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **L4-5 decompression and possible fusion Qty: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 305, 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Fusion.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back  $i\frac{1}{2}$  Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines recommend laminotomy, laminectomy, and discectomy for lumbosacral nerve root decompression. MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar decompression that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Fusion may be supported for surgically induced segmental instability. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. This injured worker presents with persistent low back pain radiating into the left lower extremity. Clinical exam findings are consistent with electrodiagnostic evidence of left L5 radiculopathy and imaging evidence of nerve root compression at the L5/S1 level. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is limited evidence of nerve root compression at two levels. There is no radiographic evidence of spinal segmental instability at L4/5 or imaging findings to support the need for a wide decompression. Additionally, there is no evidence of a psychosocial screen. Therefore, this request is not medically necessary.

#### **L5-S1 decompression and possible fusion Qty: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 305, 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Fusion.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back  $L_4^{1/2}$  Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines recommend laminotomy, laminectomy, and discectomy for lumbosacral nerve root decompression. MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar decompression that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Fusion may be supported for surgically induced segmental instability. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. This injured worker presents with persistent low back pain radiating into the left lower extremity. Clinical exam findings are consistent with electrodiagnostic evidence of left L5 radiculopathy and imaging evidence of nerve root compression at the L5/S1 level. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no radiographic evidence of spinal segmental instability at L5/S1, or imaging findings of significant spinal stenosis or facet arthropathy to support the need for a wide decompression. Additionally, there is no evidence of a psychosocial screen. Therefore, this request is not medically necessary.