Case Number:	CM15-0131875		
Date Assigned:	07/28/2015	**Date of Injury:**	04/26/2012
Decision Date:	08/26/2015	**UR Denial Date:**	06/29/2015
Priority:	Standard	**Application Received:**	07/08/2015

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:

This injured worker is a 47-year-old male who reported an industrial injury on 4/26/12. Injury occurred while he was carrying a 93-pound bag of cement over his shoulder and twisting quickly. The 1/9/15 initial neurosurgical consult cited severe mechanical axial back pain and severe neck pain with arm and leg radiculopathies, worse on the right with pain, numbness and weakness. The neurologic exam documented right anterior tibialis and extensor hallucis longus weakness, and right gastrocnemius weakness. There was diminished sensation over the right L5 and s1 dermatomes, with trace reflexes throughout. The 3/22/15 lumbar spine MRI impression documented congenitally short pedicles which mildly decreased the AP diameter of the spinal canal. At L3/4, there was a broad-based disc herniation that abuts the thecal sac. Combined with short pedicles, facet and ligamentum flavum hypertrophy, there was spinal canal narrowing as well as neuroforaminal narrowing. At L4/5, there was a broad-based disc herniation that abutted the thecal sac. Combined with short pedicles, facet and ligamentum flavum hypertrophy, there was spinal canal narrowing, as well as right greater than left neuroforaminal narrowing and impingement on the right L4 nerve root. At L5/S1, there was facet arthropathy that produced right neuroforaminal narrowing. The 6/12/15 treating physician report cited worsening, constant and intolerable lumbar spine pain radiating down both legs, right worse than left. He was unable to work and totally disabled by the pain. Pain was exacerbated with bending, twisting, prolonged sitting, getting in and out of cars or chairs, and walking. He had fallen multiple times and recently went down a full flight of stairs with substantial bruising and injury. He felt that his life was completely intolerable and he expressed suicidal thoughts because of pain levels.

Imaging findings were reviewed. The diagnosis was L5/S1 disc herniations with high-grade foraminal stenosis, left greater than right, and advanced disc deterioration L4-S1 with marked facet arthropathy and foraminal stenosis. He was felt to be a surgical candidate. Authorization was requested for posterior spinal fusion and decompression at L4/5 and L5/S1, with bilateral laminoforaminotomy and microdiscectomy at L3/4. A fusion was necessary given the advanced disc deterioration, end plate deterioration, Modic changes, and also the overt facet arthropathy, which would require greater than 50% of the facet to be removed in order to full decompress the nerve, causing temporary instability requiring a fusion. The 6/29/12 utilization review non-certified the request for posterior spinal fusion and decompression at L4/5 and L5/S1, with bilateral laminoforaminotomy and microdiscectomy at L3/4 as there were no current clinical exam findings of any motor or sensory deficit or reported EMG findings supportive of a diagnosis of lumbar nerve root compression, and there was no evidence of a psychological evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior spinal fusion and decompression at L4-5 & L5-S1, with bilateral laminoforaminotomy & microdiscectomy at L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

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-Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy 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. The Official Disability Guidelines do not recommend lumbar fusion for patients with degenerative disc disease, disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or non-specific low back pain. Fusion may be supported for segmental instability (objectively demonstrable) including excessive motion, as in isthmic or degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. Pre-operative clinical surgical indications include all of the following: (1) All physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with

rehabilitation efforts including skilled therapy visits, and performance of home exercise program during and after formal therapy. (2) X-rays demonstrating spinal instability and/or imaging demonstrating nerve root impingement correlated with symptoms and exam findings; (3) Spine fusion to be performed at one or two levels; (4) Psychosocial screen with confounding issues addressed; the evaluating mental health professional should document the presence and/or absence of identified psychological barriers that are known to preclude post-operative recovery; (5) Smoking cessation for at least six weeks prior to surgery and during the period of fusion; healing; (6) There should be documentation that the surgeon has discussed potential alternatives, benefits and risks of fusion with the patient. Guideline criteria have not been met. This injured worker presents with severe low back pain radiating down both legs with reports of multiple falls. There is no current neurologic exam documented to correlate with imaging evidence of L4 nerve root compression and plausible nerve root compression at the L3/4 and L5/S1 level. There is discussion of the need for wide decompression resulting in temporary intraoperative instability necessitating fusion. Evidence of reasonable and/or comprehensive non-operative treatment and failure has been submitted. Additionally, there are significant psychological factors documented with no evidence that a psychological evaluation has been performed and the injured worker cleared for surgery. Therefore, this request is not medically necessary at this time.