Case Number:	CM15-0162078		
Date Assigned:	08/28/2015	**Date of Injury:**	09/20/2012
Decision Date:	09/30/2015	**UR Denial Date:**	07/22/2015
Priority:	Standard	**Application Received:**	08/18/2015

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 59-year-old male who sustained an industrial injury on 9/20/12. Injury occurred relative to cumulative trauma as a truck driver, loading and unloading parts. Conservative treatment had included chiropractic, acupuncture, modified work, medication management and physical therapy. The 4/17/13 lumbar spine MRI impression documented transitional anatomy at the lumbosacral junction and mild hyperlordosis at the lumbosacral junction. There were 2 mm posterior disc bulges at L4/5 and the L5 transitional segment with mild to moderate neuroforaminal stenosis at the transitional segment. There was mild facet arthropathy bilaterally, resulting in mild to moderate neuroforaminal stenosis, slightly worse in the left. The 7/8/13 bilateral lower extremity electrodiagnostic documented no evidence of lumbosacral radiculopathy or peripheral neuropathy. The 3/24/15 treating physician cited constant low back pain with worsening radiation going down his left leg. He reported pain up to grade 7/10 and severe numbness and tingling in the legs. Pain increased with prolonged walking and decreased with pain medication. He also complained of persistent depression and was taking anti-depressants periodically. Physical exam documented normal gait, limited range of motion secondary to pain, paraspinal tenderness and spasms, and bilateral sacroiliac joint tenderness. There was a positive sitting root sign. Patellar reflexes were +3 bilaterally and Achilles reflexes were +2 bilaterally. The treatment plan recommended an EMG/NCV due to worsening radicular lower extremity pain, and prescribed continued medications. The 4/28/15 electrodiagnostic consult report documented complaints of low back pain radiating to the legs with symptoms of numbness, tingling and weakness. Physical exam documented lumbar paraspinal muscle

tenderness, decreased lumbar flexion/extension, normal gait, intact sensation, normal motor strength and tone, and normal reflexes. The EMG and NCV study findings were reported as normal. The 7/7/15 treating physician report cited low back pain radiating into both lower extremities. Lumbar spine exam documented paraspinal tenderness to palpation, normal range of motion, and normal lordosis. There was 5/5 lower extremity strength and 2+ and symmetrical deep tendon reflexes. There was negative clonus and negative straight leg raise. Sensation was diminished over the bilateral L4 dermatomes. Imaging documented L4 to L5 stenosis. The radiologist called it L5 to S1 because of a transitional segment. The diagnosis included lumbar radiculopathy. The injured worker had reportedly failed conservative treatment for more than a year and his lumbar radiculopathy was concordant with imaging findings. The treatment plan recommended L4/5 decompression and possible fusion as the foraminal stenosis may require removal of more than 50% of the facets which will cause intraoperative iatrogenic instability. Authorization was requested for outpatient L4/5 decompression and fusion. The 7/22/15 utilization review non-certified the request for outpatient L4/5 decompression and fusion as there was no evidence of spinal fracture, dislocation, instability or progressive spondylolisthesis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient L4-L5 decompression and Fusion: 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 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. Spinal instability criteria include lumbar inter- segmental translational movement of more than 4.5 mm. Pre-operative clinical

surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability and/or imaging demonstrating nerve root impingement correlated with symptoms and exam findings, spine fusion to be performed at 1 or 2 levels, psychosocial screening with confounding issues addressed, and smoking cessation for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been fully met. This injured worker presents with complaints of low back pain with worsening pain radiating in to the lower extremities with numbness, tingling and weakness. Current clinical exam findings documented a sensory loss consistent with imaging findings of plausible L4/5 nerve root compromise. There is discussion of the possible need for removal of more than 50% of the facet joints to allow for full decompression which would create temporary intraoperative instability and necessitate fusion. However, electrodiagnostic studies were negative for lumbar radiculopathy. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including physical or manual therapy, and failure has not been submitted. There is no radiographic evidence of spondylolisthesis or spinal segmental instability on flexion and extension x-rays. Potential psychological issues are documented with no evidence of a psychosocial screen. Therefore, this request is not medically necessary.