Case Number:	CM15-0168440		
Date Assigned:	09/09/2015	**Date of Injury:**	02/05/2015
Decision Date:	10/14/2015	**UR Denial Date:**	08/17/2015
Priority:	Standard	**Application Received:**	08/26/2015

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:

This injured worker is a 42-year-old male who reported an industrial injury on 2/05/15. Injury was reported relative to repetitive and continuous trauma of his job duties as a porter. Past medical history was positive for hypertension. The 3/20/15 lumbar x-ray impression documented moderate to severe straightening of the lumbar lordosis, which may reflect an element of myospasms. There were degenerative anterior superior and anterior inferior endplate osteophytes scattered at L2 through L5. The 4/17/15 initial treating physician report cited low back pain radiating to both legs. Review of systems documented complaints of depression. Physical exam documented paraspinal tenderness to palpation with normal lordosis and full range of motion. Neurologic exam documented 5/5 lower extremity strength, diminished bilateral L5 dermatomal sensation, normal deep tendon reflexes, negative clonus, and negative straight leg raise tests. The diagnosis was lumbar radiculopathy. MRI was recommended. The 5/1/15 lumbar spine MRI impression documented endplate sclerotic changes. At L3/4, there was bilateral neuroforaminal narrowing secondary to 2-3 mm broad-based posterior disc protrusion in conjunction with congenital stenosis of the thecal sac with bilateral exiting nerve root compromise. At L4/5, there was bilateral neuroforaminal narrowing secondary to 2 mm broad-based posterior disc protrusion in conjunction with facet joint hypertrophy. Canal stenosis was seen in conjunction with congenital stenosis of the thecal sac, and bilateral exiting nerve root compromise was seen. At L5/S1, there was bilateral neuroforaminal narrowing secondary to 3-4 mm broad-based posterior disc protrusion with central canal stenosis and bilateral exiting nerve root compromise seen. The 7/10/15 treating physician report indicated that the lumbar epidural steroid injection on 6/17/15

provided relief for only one day. Lumbar spine exam documented paraspinal tenderness to palpation with normal range of motion. Sensory loss was diminished over the bilateral L5 dermatomes. The diagnosis was lumbar radiculopathy refractory to conservative treatment with anti-inflammatories, physical therapy, and epidural injection. The treatment plan recommended L5 to S1 decompression and possible fusion since he had failed conservative treatment and had neurologic deficits that were concordant with his MRI findings. The 8/4/15 treating physician report appealed the denial of L5/S1 lumbar decompression and possible fusion surgery as the injured worker had diminished L5 dermatomal sensation, which was concordant with imaging findings of bilateral neuroforaminal narrowing with pressure on the L5 nerve root which was consistent with physical exam. Authorization was again requested for L5/S1 lumbar decompression and possible fusion surgery. The 8/17/15 utilization review non-certified the appeal request for L5/S1 lumbar decompression and possible fusion surgery as there was no documentation of any subjective complaints, and there was no finding of radiographic instability or a reasonable expectation of post decompression iatrogenic instability to justify a possible fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 lumbar decompression and possible fusion: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. 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 in both 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

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 met. This injured worker presents with low back pain radiating into both legs. Clinical exam findings are consistent with imaging evidence of nerve root compromise 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 spondylolisthesis or spinal segmental instability on flexion and extension x-rays. There is no discussion or imaging evidence supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. Potential psychological issues are documented with no evidence of a psychosocial screen. Therefore, this request is not medically necessary.