

<b>Case Number:</b>	CM15-0190766		
<b>Date Assigned:</b>	10/05/2015	<b>Date of Injury:</b>	09/28/2014
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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: Minnesota, Florida  
 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 55-year-old male, with a reported date of injury of 09-28-2014. The diagnoses include a 4mm anterolisthesis at L5-S1 and chronic L5 radiculopathy. Treatments and evaluation to date have included Tramadol, Tylenol, and physical therapy (failed). The diagnostic studies to date have included a urine drug screen on 06-26-2015 with inconsistent findings for Morphine; and electrodiagnostic studies of the lower extremities which showed evidence of left active on chronic L5 radiculopathy. The initial orthopedic spinal consultation report dated 08-24-2015 indicates that the injured worker complained of low back pain with radiation down the left leg. He described numbness and tingling in the left leg. The injured worker's pain was rated 8 out of 10, and worse at night. It was noted that the injured worker had not been able to work because of the pain. The injured worker was limping and had weakness in his leg. It was noted that the pain was progressively getting worse. The injured worker performed his activities of daily living with some difficulty. The objective findings included depression and anxiety; diffuse paraspinal tenderness and spasm of the lumbar spine; normal strength in the bilateral hip; decreased sensation to the lateral and plantar left foot; reflexes were 2+ in the bilateral knee and Achilles; positive Kemp sign; and positive pain with lumbar flexion and extension. It was noted that an x-ray of the lumbar spine on 08-24-2015 showed a 6mm anterolisthesis with forward flexion that corrected to a 1mm anterolisthesis with extension; an MRI of the lumbar spine on 10-27-2014 showed broad-based disc protrusion at L4-5, moderate facet joint arthropathy resulting in mild to moderate left-sided foraminal narrowing; 4mm anterolisthesis of L5 on S1 with marrow swelling in the right L5 pedicle; a mild disc bulge; and

moderate foraminal narrowing due to moderate facet joint arthropathy, end plate osteophytes, and foraminal extension of the disc. The treating physician indicated that the injured worker's condition had "failed to improve with conservative treatment modalities-his symptoms are debilitating and he is experiencing neurologic deficits with weakness and numbness in his left leg". It was noted that the injured worker was more interested in permanently fixing his problem because he wanted to return to his normal life and function. The option of L5-S1 decompression and fusion was discussed between the treating physician and the injured worker. The treating physician felt that the surgery would help provide interbody support and help to stabilize the spine, prevent further translation, and would help to significantly decreased the back and leg pain. The injured worker's disability status was deferred to the primary treating physician. On 08-25-2015, the primary treating physician instructed the injured worker to return to modified work. The treating physician requested one lumbar decompression and transforaminal lumbar interbody fusion at L5-S1 level. On 09-16-2015, Utilization Review (UR) non-certified the request for one lumbar decompression and transforaminal lumbar interbody fusion at L5-S1 level.

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

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

#### **1 Lumbar decompression and transforaminal lumbar interbody fusion at the L5-S1 level: 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) Treatment for Workers Compensation Online Edition 2015 Chapter: Low Back- Lumbar & Thoracic.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation ODG: Section: Low back, Topic: Fusion.

**Decision rationale:** The injured worker is a 55-year-old male with a date of injury of 9/28/2014. Progress notes dated August 24, 2015 indicate complaints of low back pain with radiation down the left lower extremity associated with numbness and tingling in the left leg. Pain level was 8/10. He did not use alcohol but was smoking 5 cigarettes per day. On examination there was slight weakness of the left extensor hallucis longus at 4/5 and gastrocnemius as well. There was decreased sensation on the lateral and plantar aspect of the left foot. Reflexes were 2+ in bilateral knees and Achilles. There was a positive Kemp sign and positive pain with lumbar flexion and extension. X-rays of the lumbar spine dated August 24, 2015 including flexion/extension views demonstrated 6 mm of anterolisthesis with forward flexion that corrected to 1 mm of anterolisthesis with extension for 8 total of 5 mm of translation. MRI scan of the lumbar spine dated 10/27/2014 revealed broad-based disc protrusion at L4-5 without significant narrowing of the spinal canal. Moderate facet joint arthropathy resulted in mild to moderate left-sided foraminal narrowing. At L5-S1 there was 4 mm anterolisthesis with marrow edema in the right L5 pedicle. A mild disc bulge was present without significant narrowing of the spinal canal. Moderate foraminal narrowing was present secondary to moderate facet joint arthropathy, and plate osteophytes and foraminal extension of disc. The exiting left L5 nerve root appeared

to contact disc material within the foraminal zone. The documentation indicates that the iw had tried physical therapy which was making him worse. He had completed 12 sessions. His symptoms had been present for over a year. He had failed conservative treatment. His symptoms were debilitating and he was experiencing neurologic deficits with weakness and numbness in the left leg. A prior EMG and nerve conduction study of June 2015 showed evidence of left chronic L5 radiculopathy. A request for surgery was noncertified due to a lack of psychological evaluation and abstinence from smoking prior to surgery. The injured worker meets the guideline criteria for the requested surgical procedure. However, according to California MTUS as well as ODG guidelines a psychosocial screen is recommended prior to surgery for documentation of the presence and/or absence of identified psychological barriers that are known to preclude postoperative recovery. ODG guidelines also recommend that the injured worker refrain from smoking for at least 6 weeks prior to surgery and during the period of fusion healing. The documentation submitted does not indicate that this has been done. As such, the request for lumbar decompression and transforaminal lumbar interbody fusion at L5-S1 is not supported at this time and the medical necessity of the request has not been substantiated.