

<b>Case Number:</b>	CM15-0205928		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	10/02/2008
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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 51-year-old female who sustained an industrial injury on 10/2/08. Injury occurred when she was working as a driver and slipped while exiting a vehicle. She hit her left knee on the steps and fell onto both knees on the ground. She had not worked since 2009. Past medical history was positive for hypertension, osteoporosis, gastrointestinal issues, and psychiatric treatment. MRI findings on 10/20/09 reportedly revealed spondylolisthesis with bilateral pars fracture and approximately 4.5 mm of transition at L5/S1 with evidence of significant neuroforaminal and L4/5 facet arthropathy. Records documented lumbar x-ray findings on 3/23/10 demonstrating 10 mm anterolisthesis of L5 on S1 with probable pars defects. She underwent a left L5/S1 transforaminal epidural steroid injection on 5/12/15 with slight relief of her low back pain and on-going constant pain in both legs to her toes and heels. The 6/20/15 lumbar spine MRI impression documented mild neuroforaminal stenosis with mild impression upon the L5 nerve roots as they exit the neural foramina. These findings were caused by degenerative disc narrowing, small bulge, and grade 1 anterior spondylolisthesis of L5 on S1. Findings documented marked disc desiccation and narrowing at L5/S1. There was L5 spondylosis with grade 1 anterior spondylolisthesis of L5 on S1 with partial uncovering of the disc with a 2-3 mm disc bulge. The 6/20/15 lumbar spine x-rays documented L5/S1 degenerative disc narrowing, spondylosis, and grade 1 anterior spondylolisthesis of L5 on S1. The 9/29/15 treating physician report cited continued low back pain with left greater than right lower extremity pain, numbness, and weakness. She reported severe pain in the back and down the legs with weakness requiring a cane. She had pain at night and difficulty sleeping.

Conservative treatment had included epidural injections and physical therapy. Physical exam documented difficulty heel and toe walking, left antalgic gait, 4/5 bilateral extensor hallucis longus weakness, and diminished L5 dermatomal sensation on the left. X-rays and MRI confirmed grade 2 L5/S1 lytic spondylolisthesis with anterior spondylolisthesis and severe foraminal narrowing. The treatment plan recommended surgical decompression and fusion. The injured worker required a psychological evaluation due to her depression and internist evaluation due to her gastric issues from pain and anti-inflammatory medications. Authorization was requested for an L5/S1 laminectomy and fusion. The 10/9/15 utilization review non-certified the request for L5/S1 laminectomy/fusion as there was no evidence of lumbar instability to support the medical necessity of fusion.

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

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

#### **L5-S1 laminectomy/fusion: Upheld**

**Claims Administrator 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, Fusion (spinal).

**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 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 laminectomy 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 includes 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 6weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been fully met. This injured worker presents with severe and function-limiting low back pain radiating down both legs with numbness and weakness. Clinical exam finding are consistent with imaging evidence of nerve root compromise at the L5/S1 level. There is current radiographic evidence of grade 1 spondylolisthesis. The treating physician has reported grade 2 spondylolisthesis at L5/S1. However, there is no spinal segmental instability documented by 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 at this time.