

<b>Case Number:</b>	CM15-0211492		
<b>Date Assigned:</b>	10/30/2015	<b>Date of Injury:</b>	06/19/2013
<b>Decision Date:</b>	12/22/2015	<b>UR Denial Date:</b>	10/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2015

### 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 41 year old male, who sustained an industrial injury on 6-19-2013. He had been treated for a left sided herniation at L4-5 with a large extruded fragment. He had a left foot drop and evidence of L5 radiculopathy on the left. The foot drop has since resolved. Updated MRI of the lumbar spine dated April 28, 2015 revealed severe loss of disc height at L4-5 with endplate degenerative marrow edema. Broad-based disc bulging with 4 mm central and right paracentral disc protrusion with annular tear effaces anterior thecal sac. The protruded disc minimally contacts descending right L5 nerve root. Mild bilateral facet arthropathy. Findings resulted in mild bilateral neural foraminal narrowing and mild narrowing of right subarticular recess. No canal stenosis. At L5-S1 there is grade 1 anterolisthesis with 2 mm broad-based disc bulging effaces anterior epidural fat. Bilateral pars defects. Mild bilateral facet arthropathy. Findings resulted in mild bilateral neural foraminal narrowing. No canal stenosis. Per examination of 10/2/2015 the injured worker was complaining of low back pain radiating into the left leg. (Please note the prior MRI scan dated July 7, 2013 had revealed a left-sided L4-5 disc protrusion with an extruded fragment but the April 28 2015 MRI does not show the left sided protrusion or nerve root compression) He stated that it started in 2013 and there was minimal improvement with anti-inflammatories and physical therapy as well as an epidural steroid injection which gave him relief for a few days. On examination there was tenderness to palpation over the paraspinal musculature. Normal range of motion is documented. Neurologic examination revealed 5/5 strength in both lower extremities in all muscle groups. Sensation was diminished over the left L4 dermatome. Reflexes were 2+ in the patellae and Achilles. There

was no clonus. Straight leg raising was negative. The provider reviewed the MRI scan which showed L4-5 disc collapse causing foraminal stenosis. The assessment was lumbar radiculopathy. The recommendation was L4-5 decompression with fusion.

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

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

#### **Lumbar decompression with fusion L4-5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

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

**Decision rationale:** California MTUS guidelines indicate that patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with the natural history, placebo or conservative treatment. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem in the absence of spinal fracture, dislocation or spondylolisthesis if there is instability and motion in the segment operated on. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. In this case the injured worker is complaining of left sided radicular pain and sensation is diminished over the left L4 dermatome but the MRI does not show a left-sided nerve root compression at this time although it did show an extruded disc on the left side in 2013 which has since resolved. In any case flexion/extension films have not been provided and there is no documentation of instability. The right-sided protrusion at L4-5 is not causing significant nerve root compression and straight leg raising is negative and there is no neurologic deficit in the right lower extremity. The MRI shows mild neural foraminal narrowing at L4-5 bilaterally. As such, there is no need for a wide decompression and iatrogenic instability will not be created. Therefore there is no indication for a spinal fusion. As such, the guidelines do not support the request for decompression and fusion at L4-5 and the medical necessity of the request has not been substantiated, therefore is not medically necessary.