

<b>Case Number:</b>	CM15-0213939		
<b>Date Assigned:</b>	11/03/2015	<b>Date of Injury:</b>	07/01/2014
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	10/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2015

### 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 54-year-old female who sustained an industrial injury on 7/1/14, due to repetitive lifting as a baker. Past medical history was reported as negative. Past surgical history was positive for left knee surgery and bilateral carpal tunnel releases. Social history documented he did not smoke. The 3/5/15 lower extremity EMG/NCV study documented peroneal nerve entrapment at the left ankle. There was no evidence of lumbar radiculopathy. The 7/9/15 orthopedic spine surgery report cited back and bilateral leg pain. Functional difficulty was documented precluding work. Pain medications were not helping. The injured worker had failed 3 epidural steroid injections and months of therapy. MRI was reviewed and demonstrated grade 1 spondylolisthesis at L4/5 with spinal stenosis that was moderate to severe. There were no lumbar spine x-rays available for review. There were no new motor or sensory deficits noted. Straight leg raise was positive and range of motion was decreased. The treatment plan recommended lumbar decompression and fusion at L4/5. The 9/21/15 lumbar spine MRI impression documented moderate degenerative disc disease with a central disc herniation and significant ligamentum flavum hypertrophy and facet arthropathy leading to a grade 1 anterolisthesis with probable impingement of the bilateral transiting and exiting nerve roots. There was moderate degenerative disc disease, ligamentum flavum hypertrophy, and facet arthropathy at the L5/S1 level, likely impinging on the bilateral exiting nerve roots. There were mild to moderate disc bulges with ligamentum flavum hypertrophy and facet arthropathy at L1/2, L2/3, and L3/4 without evidence for significant nerve root impingement. The 10/1/15 treating physician report cited continued significant low back pain and instability. There was numbness and tingling, cramping, and weakness in his bilateral lower extremities, and

bilateral right hip pain. Current medications included tramadol, cyclobenzaprine, and Norco. Physical exam documented paraspinal muscle tenderness and spasms, decreased bilateral L5 dermatomal distribution, restricted range of motion, 4/5 bilateral long toe extensor and ankle plantar flexion weakness, 2+ and symmetrical deep tendon reflexes, inability to heel/toe walk, and positive straight leg raise. The diagnosis included lumbar radiculopathy. Surgery would be requested on behalf of the orthopedic surgeon. A lumbar support was recommended to provide him more stability. The injured worker was capable of modified work. Authorization was requested for lumbar decompression and fusion at L4/5, left-sided approach, and lumbar support. The 10/12/15 utilization review non-certified the request for lumbar decompression and fusion at L4/5, left-sided approach as there was no documentation of nicotine status, no documentation of spinal instability on flexion/extension films, normal EMG/NCV, no psych clearance, and no evidence of current injections, home exercise program, and/or physical therapy. The request for lumbar support was non-certified as there was no note of core truncal strengthening and/or home exercise program/physical therapy.

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

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

#### **Lumbar decompression and fusion L4-L5 left side approach: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Lumbar spine.

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

**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 decompression 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 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 to both lower extremities with numbness, tingling and weakness. Functional difficulty precludes return to full duty work. Clinical exam findings are consistent with imaging evidence of nerve root impingement at the L4/5 level. Evidence of long-term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is radiographic evidence of grade 1 spondylolisthesis at L4/5 but there is no evidence of spinal segmental instability on flexion and extension x-rays. There is no discussion supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. There is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.

**Lumbar support:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Lumbar spine.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138-139.

**Decision rationale:** The California MTUS guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The revised ACOEM Low Back Disorder guidelines do not recommend the use of lumbar supports for prevention or treatment of lower back pain. However, guidelines state that lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. The use of a lumbar support for pain control and with documented spondylolisthesis is consistent with guidelines. Therefore, this request is medically necessary.