

<b>Case Number:</b>	CM15-0220507		
<b>Date Assigned:</b>	11/13/2015	<b>Date of Injury:</b>	08/09/2010
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	10/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/09/2015

### 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 36-year-old male who sustained an industrial injury on 8/9/10. Injury occurred while he was picking peaches and fell off a ladder. The 3/13/15 bilateral lower extremity EMG/NCV study documented findings consistent with an L5/S1 lumbar radiculopathy. Records documented conservative treatment to include medications and activity modification. The 10/2/15 treating physician report cited low back pain centered over the bilateral sacroiliac joint and mid back. Pain radiated into both legs with associated numbness and tingling. Pain was aggravated by twisting, bending, or lifting. He was anxious and depressed and pending psychiatrist referral. Current medications included Fexmid, Lunesta, Nalfon, Paxil, Prilosec, Ultram ER, and Norco. Lumbar spine exam documented paraspinal and bilateral sacroiliac joint tenderness, decreased range of motion secondary to pain and stiffness, positive FABERE/Patrick's test and positive straight leg raise bilaterally. Lower extremity neurologic exam documented 5/5 strength, diminished bilateral S1 dermatomal sensation, and symmetrical 1+ deep tendon reflexes. The diagnosis included lumbar discopathy with disc displacement and lumbar radiculopathy. The treatment plan recommended continued medications, lumbar epidural steroid injections at L4/5, and psychiatric consultation for depression. The treating physician stated that if lumbar epidural steroid injections failed to alleviate his low back pain, he might be a candidate based on his MRI findings and symptoms for interspinous fixation on an outpatient basis. Authorization was requested for interspinous lumbar fixation. The 10/21/15 non-certified the request for interspinous lumbar fixation as there was no clinical rationale for this procedure.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Interspinous lumbar fixation:** Upheld

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

**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: 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 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 into the bilateral lower extremities with numbness and tingling. Clinical exam findings were consistent with electrodiagnostic evidence of bilateral L4/5 radiculopathy. There were no lumbar spine imaging studies provided or documented in the submitted records. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. 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. This injured worker does not meet guideline criteria for fusion to support the medical necessity of an interspinous fixation device. Therefore, this request is not medically necessary.