

<b>Case Number:</b>	CM15-0047589		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	12/31/2012
<b>Decision Date:</b>	05/05/2015	<b>UR Denial Date:</b>	02/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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:

The injured worker is a 51-year-old female who sustained an industrial injury on 12/31/12, relative to a trip and fall. Past medical history was reported as negative for hypertension, diabetes, or cardiac, pulmonary, renal, or gastrointestinal disorders. She denied smoking and alcohol consumption. Conservative treatment included chiropractic, physical therapy, medication management, activity restrictions, modified work, epidural steroid injection, and sacroiliac joint injection. The 8/4/14 lumbar spine MRI impression documented a 3-mm left foraminal disc protrusion at L5/S1 with abutment of the exiting left L5 nerve root. There was disc desiccation, endplate degenerative changes, and facet arthropathy at L5/S1. At L4/5, there was a 2 mm circumferential disc protrusion resulting in abutment of the descending L5 nerve roots bilaterally. There was normal disc height, endplate degenerative changes, and facet arthropathy, with a mild degree of central canal narrowing. At L3/4, there was normal disc height, mild endplate degenerative changes, and facet arthropathy with mild central canal narrowing. The 1/27/15 treating physician report cited on-going low back, left hip and leg pain associated with weight bearing and bending. Physical exam documented bilateral sciatic notch tenderness, restricted lumbar range of motion, normal lower extremity motor strength, and positive straight leg raise, left greater than right. There was decreased sensation in the left L5/S1 distribution. The diagnosis included multi-factorial spinal stenosis at L4/5, and to a lesser degree at L3/4. The injured worker had failed conservative treatment. The injured worker reported she had undergone a psychiatric evaluation, but no specific clearance for surgery was documented. Authorization was requested for lumbar decompression and fusion at L4/5 and decompression at

L3/4. The 2/10/15 utilization review non-certified the request for a lumbar decompression at L3/4 and lumbar decompression and fusion at L4/5 with instrumentation and intraoperative monitoring, cell saver and 2-4 day inpatient stay. The utilization review documented a peer-to-peer call in which the treating physician opined there was stenosis at L3/4 to support this request and that on occasion sufficient decompression is required for patients with stenosis that destabilizes the spine necessitating fusion. The rationale for non-certification stated that the submitted imaging documentation did not support surgical intervention at the L3/4 level or this injured worker's specific need for decompression that would result in intraoperative instability.

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

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

#### **Lumbar Decompression and Fusion at L4-5 and Decompression at L3-4 with Instrumentation and Intraoperative Monitoring and Cell Saver: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers Comp 19th Edition, 2014, Low Back and Lumbar Thoracic Chapter, Intraoperative neurophysiological monitoring (during surgery).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines recommend lumbar decompression for carefully selected patients with nerve root compression due to lumbar disc prolapse. MTUS guidelines indicate that lumbar spinal fusion may be considered for patient with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there is no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar decompression surgery 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. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Fusion may be supported for surgically induced segmental instability. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. This injured worker presents with persistent low back and left lower extremity pain and sensory loss in the left L5/S1 distribution. There is imaging evidence of L4/5 and L5/S1 disc protrusion with abutment of the L5 nerve roots. There is mild central canal narrowing and facet arthropathy at L3/4 but no evidence of nerve root compression. There is no imaging evidence of

spinal segmental instability or discussion in the treating physician reports of the need for wide decompression and potential for temporary intraoperative instability. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. A psychiatric evaluation was reported by the patient but there was no documentation as to the findings or appropriate candidacy for fusion surgery. Therefore, this request is not medically necessary.

**Associated Surgical Service: Inpatient Stay (2-4 days):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Hospital length of stay (LOS).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.