

Case Number:	CM15-0050834		
Date Assigned:	03/24/2015	Date of Injury:	12/21/2013
Decision Date:	05/07/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	03/17/2015

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 41-year-old male who sustained an industrial injury on 12/21/13. Injury occurred when he slipped and fell exiting his vehicle and hitting his low back. The 2/28/14 lumbar spine MRI impression documented multilevel degenerative changes involving disc bulging, facet arthropathy, and ligamentum flavum redundancy along with congenitally short pedicles resulting in variable levels of spinal canal and lateral recess stenosis. There was moderate right neuroforaminal encroachment at L5/S1. At L4/5, there was mild bilateral lateral recess stenosis, left greater than right, and no advanced neuroforaminal encroachment. The 6/23/14 electrodiagnostic report documented findings consistent with right L5/S1 radiculopathy. The 9/9/14 lumbosacral flexion/extension x-rays documented minimal narrowing of the fourth and fifth lumbar discs with subtle stable anterolisthesis of L5 upon S1 and only minimal anterolisthesis of L4 upon L5 during extension. The 1/27/15 treating physician report cited increased low back pain radiating down his right buttocks and into both legs. Pain was constant 10/10 and associated with leg weakness. Numbness was reported down both legs, worse on the right. Pain was made worse with everything and relieved with nothing. Physical exam documented antalgic gait with small steps and forward flexed posture. There was generalized tenderness and sensitivity to touch, right dorsiflexion weakness, absent right Achilles reflex, decreased lumbar range of motion, and positive straight leg raise. The diagnosis was lumbar radiculopathy, lower back pain, degenerative disc disease lumbar spine, and herniated nucleus pulposus lumbar spine. The treatment plan recommended proceeding with spine surgery. He was off work. The 2/20/15 utilization review non-certified the request for L5/S1 laminectomy and

fusion with pedicle rods and screws due to an absence of an MRI report and detailed documentation of degenerative changes at more proximal levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 Laminectomy and Fusion with Pedicle Rods and Screws: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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 i½ 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 or spinal stenosis. 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. Before referral for surgery, consideration of referral for psychological screening is recommended 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. 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 constant severe function-limiting low back pain radiating to the lower extremities with numbness and weakness. Clinical exam findings are consistent with imaging and electrodiagnostic evidence of right L5/S1 radiculopathy and moderate stenosis. There is no radiographic evidence of instability or discussion of the need for wide decompression that would create temporary intraoperative instability. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no evidence of psychosocial screening. Therefore, this request is not medically necessary.

Associated surgical service: Inpatient One Night Stay: 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 $\frac{1}{2}$ 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.