

<b>Case Number:</b>	CM15-0051472		
<b>Date Assigned:</b>	03/24/2015	<b>Date of Injury:</b>	01/18/2013
<b>Decision Date:</b>	05/05/2015	<b>UR Denial Date:</b>	02/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2015

### 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 69-year-old female who sustained an industrial injury on 1/18/13. Injury occurred when her shoe got caught and she tripped, twisting her right ankle, foot, and toe. She sustained a right 5th metatarsal fracture, which was reported as healed but malaligned with surgery pending. Conservative treatment for her lumbar spine complaints had included medication management, physical therapy, chiropractic, acupuncture, activity modification and medications. The 10/23/14 Dexa scan documented osteoporosis. The 10/28/14 lumbar spine MRI conclusion documented spondylotic changes throughout the lumbar spine. At L2/3, there was a 2 mm broad-based posterior disc protrusion effacing the ventral surface of the thecal sac without evidence of canal stenosis or neuroforaminal narrowing. At L3/4, there was a 3-4 mm broad-based posterior disc protrusion that effaced the ventral thecal sac without evidence of neuroforaminal stenosis. Canal stenosis was seen. At L4/5, there was a 2-3 mm broad-based posterior disc protrusion effacing the ventral surface of the thecal sac resulting in bilateral neuroforaminal narrowing and canal stenosis. Facet joint hypertrophy and bilateral exiting nerve root compression were seen. At L5/S1, there was 4-5 mm broad-based posterior disc protrusion effacing the ventral surface of the thecal sac resulting in canal stenosis and neuroforaminal narrowing. There was bilateral exiting nerve root compression, and endplate sclerotic changes within the inferior endplate of L5 and superior endplate of S1. The 10/28/14 MRI of the lumbar spine in flexion and extension documented extensive disc pathology throughout the entire lumbar spine with accompanying canal stenosis and neuroforaminal narrowing. There was no documentation of instability. The 12/20/14 orthopedic report cited continued back and bilateral

leg pain from the anterior and posterior thigh down her legs to the feet. Physical exam documented 2+ lumbar paraspinal muscle spasms and tenderness, and +2 and symmetrical deep tendon reflexes. There was decreased sensation over the right L5 dermatome, and 4+/5 left extensor hallucis longus weakness. MRI showed spinal stenosis secondary to a disc bulge at L3/4, and L5/S1 degenerative disc disease, disc space narrowing with spinal stenosis and bilateral foraminal stenosis. X-rays showed arthritic facet joint changes at L4/5 and L5/S1, with degenerative disc disease L5/S1 and possible transitional level lumbar vertebrae, with normal L5 transverse processes. There was no instability or motion on flexion/extension. The diagnosis included lumbar spinal stenosis L5/S1 with bilateral foraminal stenosis, lumbar spinal stenosis L2-L4, and osteoporosis. The treatment plan recommended posterior lumbar interbody fusion at L5/S1 to decompress the nerve root and cauda equina to stabilize the spine, and lumbar laminectomy at L3/4. The 2/21/15 utilization review non-certified the request for lumbar interbody fusion L5/S1 and lumbar laminectomy L3/4 as there was a lack of disabling lower extremity symptoms, and no imaging evidence of instability.

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

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

#### **Lumbar interbody fusion at L5-S1, lumbar laminectomy L3-4: 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 1½ Lumbar & Thoracic, Discectomy/Laminectomy, 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. 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 stated there was 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. The Official Disability Guidelines recommend criteria for lumbar discectomy and 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. 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 patient presents with low back and bilateral lower extremity radicular pain. Clinical exam findings were consistent with imaging findings of L5 nerve root compression. However, there were no clinical exam findings and/or limited imaging evidence of nerve root compression at the L3/4 level. There was no radiographic evidence of spinal segmental instability. A psychosocial screening was not evidenced. Records suggested that the patient was participating in on-going conservative therapies, including acupuncture and aquatic therapy, with no evidence of conservative treatment failure. Smoking status was not documented. Therefore, this request is not medically necessary at this time.