

<b>Case Number:</b>	CM15-0089238		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	12/01/2010
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	04/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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 49-year-old female who sustained an industrial injury on 12/01/10. Injury occurred while pushing a patient into the delivery room. Past medical history was reported as negative. Records documented prior psychiatric evaluation on 2/27/13 and psychological testing on 3/1/13 with a reported 8% whole person impairment. The 2/24/15 neurosurgical report indicated that the injured worker was last seen on 11/26/14. Current subjective complaints included grade 9/10 low back pain radiating down both legs to the feet with numbness and tingling, left greater than right. She reported intermittent foot drop bilaterally, but not occurring now. She had undergone multiple epidural steroid injections without significant relief, and a recent sacroiliac joint injection with minimal benefit. Physical exam documented significant lumbosacral and sacroiliac tenderness, marked decrease in lumbar range of motion due to pain, decreased left L4 and L5 and right L5 sensation, 4/5 left first toe extension, difficulty heel walking on the left, somewhat decreased balance with tandem walking, diminished left patellar reflex, trace bilateral ankle reflexes and no ankle clonus. The 3/12/14 lumbar spine MRI showed mild disc desiccation and L4/5 and L5/S1 disc bulging with mild compression of the thecal sac. There was no significant neuroforaminal stenosis. She had failed numerous conservative measures, including therapy, medications and multiple spinal injections. She had been out of work for at least a year and wanted to pursue surgical treatment. The treatment plan included L4/5 and L5/S1 decompression and fusion. The 4/17/15 utilization review non-certified the request for L4/5 and L5/S1 decompression and fusion as the most recent

MRI submitted for review was outdated; there was no psychosocial evaluation, and no documentation of recent physical therapy.

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

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

**L4-5, L5-S1 decompression, fusion:** Upheld

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

**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, Discectomy/Laminectomy, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines recommend decompression for lumbosacral nerve root decompression. MTUS guidelines indicate that lumbar spinal fusion may be considered for patients 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 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. 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. For any potential fusion surgery, it is recommended that the patient refrain from smoking 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 severe function-limiting low back pain radiating down both legs to the feet. Clinical exam findings are consistent with plausible imaging evidence of L4/5 and L5/S1 neurocompression. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no radiographic evidence of spinal segmental instability or imaging evidence suggestive of the need for wide decompression. There is documentation suggestive of potential psychological issues with no evidence of psychosocial screening for surgery. Therefore, this request is not medically necessary.

**Associated surgical services: Inpatient stay x 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.