

<b>Case Number:</b>	CM14-0137100		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	02/22/2013
<b>Decision Date:</b>	11/10/2014	<b>UR Denial Date:</b>	07/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

35-year-old male security guard sustained an industrial injury on 2/22/13. Injury occurred when he bent down to pick up trash from the floor. When he came back up, he hit the lower edge of a counter with his back with immediate low back and leg pain. Past medical history was positive for hypertension and morbid obesity. The 10/22/13 EMG/NCV findings were consistent with possible left S1 radiculopathy. The 4/22/14 lumbar MRI impression documented degenerative changes in the lumbar spine with improvement at the L5/S1 level and progression at the L4/5 level compared to the 5/28/13 study. There was mild spinal canal stenosis and moderate right lateral recess narrowing at L4/5. There was a 4 mm central/right paracentral disc protrusion at L4/5 which contacted the right L5 nerve root in the right lateral recess. There was moderate narrowing of the left lateral recess at L5/S1 with a 3 mm left paracentral disc protrusion which contacted the left S1 nerve root. There was a 3 mm central disc protrusion at T11/12 which contacted the spinal cord and caused mild spinal canal stenosis. The facet joints were reported unremarkable at the L4/5 and L5/S1 levels by the radiologist. The ligamentum flavum measured 2 mm in thickness on both sides. The 7/8/14 treating physician report cited grade 8/10 constant low back pain radiating down both legs to the ankles, headaches and left jaw pain. Physical exam documented upright posture, non-antalgic gait, and negative toe/heel walk. Lumbar range of motion was decreased in flexion 30/90 degrees and extension 15/25 degrees, with lateral flexion normal. There was right quadriceps atrophy and right knee range of motion 0-95 degrees. The diagnosis was disc protrusions T11-S1, multilevel spinal stenosis T11-S1, degenerative disc disease, lumbar radiculopathy, and small effusion right knee. The treatment plan recommended a lumbar brace. The 7/9/14 initial spine consult report cited grade 8/10 low back pain radiating to the legs and neck. Minimal improvement was documented with anti-inflammatories and physical therapy. Lumbar spine exam documented paraspinal tenderness with full range of motion in all

planes. There was bilateral 4/5 weakness in ankle dorsiflexion, big toe dorsiflexion, and ankle plantar flexion. Lower extremity sensation was intact in all dermatomes, reflexes were +2 and symmetrical, and straight leg raise was negative. The diagnosis was L4 through S1 radiculopathy. The treatment plan recommended L4 through S1 decompression and possible fusion. The surgeon opined the need to remove more than 50% of the facets in order to fully decompress the dorsal sac and transversing/exiting nerve roots which would cause iatrogenic instability and require fusion. The 7/25/14 utilization review denied the request for L4-S1 fusion as there was no evidence of significant contributory facet joint pathology to support the need for extensive facetectomy at the time of decompression, no detailed documentation of conservative treatment, and no evidence of a pre-op psychological evaluation.

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

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

**L4-S1 Fusion:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Fusion (spinal)

**Decision rationale:** The California MTUS guidelines state that lumbar fusion is not recommended as a treatment for patients with radiculopathy from disc herniation. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Fusion is recommended for objectively demonstrable segmental instability, including surgically induced 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. There is no evidence of a progressive neurologic deficit or severe spinal instability. There is no evidence of significant facet joint disease to warrant extensive facetectomy. Evidence of 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. A psychosocial screen is not evidenced. Therefore, this request of L4-S1 Fusion is not medically necessary and appropriate.