

<b>Case Number:</b>	CM14-0178813		
<b>Date Assigned:</b>	11/03/2014	<b>Date of Injury:</b>	05/14/2012
<b>Decision Date:</b>	06/29/2015	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/28/2014

### 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. 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 54-year-old male who sustained an industrial injury on 5/14/12. Injury occurred when he jumped backwards off a forklift, twisted his ankle and fell on his buttock. He was diagnosed with lumbago, lumbar radiculopathy, lumbar facet dysfunction, anxiety, depression and bilateral knee degenerative joint disease. Past medical history was reported negative. Past surgical history was positive for left knee surgery. He reportedly smoked occasionally. The 1/15/14 lumbar spine MRI impression documented slight left apical curvature and loss of mid upper lumbar lordosis. There was moderate disc desiccation and narrowing throughout the lower lumbar spine. At L2/3, there was 2 mm right greater than left disc bulge with mild right greater than left neuroforaminal stenosis, and mild central canal stenosis. At L3/4, there was a 3 mm broad left foraminal protrusion with mild to moderate left neuroforaminal stenosis. The disc indented the thecal sac with moderate central canal stenosis. At L4/5, there was a 4 mm posterior rightward bulge or protrusion with moderately severe central canal stenosis and moderate right greater than left neuroforaminal stenosis. At L5/S1, there was a 4 mm disc bulge greater on the right with moderately severe right greater than left neuroforaminal stenosis. There was moderate central canal stenosis. The 7/21/14 electrodiagnostic study revealed findings of chronic bilateral L4/5 radiculopathy. Records indicated the injured worker was attending group psychotherapy in July, August and September 2014. The 9/25/14 neurosurgical report cited on-going neck and low back pain. He continued with physical therapy but it had not made any improvement. He had an electrical stimulator but felt too anxious to continue with it. He did not want epidural steroid injections as he had

systemic problems following knee injections. Physical exam documented antalgic gait, difficulty transitioning from sit to stand. Reflexes were +1 and symmetrical. He has 5/5 lower extremity strength and intact sensation. Straight leg raise was negative bilaterally. He had diffused back tenderness. Imaging demonstrated multilevel degenerative changes with significant stenosis at L3/4, L4/5, and L5/S1. The diagnosis was multicompartamental stenosis at L3/4, L4/5, and L5/S1. The injured worker had failed physical therapy and was not willing to have any further interventional procedures. He had back and leg pain. The treatment plan recommended L3-S1 laminectomy, bilateral facetectomies, and transforaminal lumbar interbody fusion. The surgeon stated that a wide decompression was indicated and would create surgically induced instability. The 10/7/14 utilization review non-certified the request for L3-S1 laminectomy, bilateral facetectomies, and transforaminal lumbar interbody fusion, and associated surgical requests, as there was no objective evidence of neural compromise at the proposed surgical levels, imaging studies were not supported by clinical findings, activity limitation and progressive symptoms were not evidence, and there was no documentation that conservative treatment had been exhausted. The request for psychological/psychiatrist evaluation was non-certified as not supported.

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

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

#### **L3-S1 Laminectomy, Bilateral Facetectomies and Transforaminal Lumbar Interbody Fusion: 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 Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines recommend laminectomy 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 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 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 with low back and bilateral lower extremity pain. There is no documentation of a radicular pain distribution. Clinical exam findings do not evidence motor, reflex or sensory loss consistent with nerve root compression the levels of the proposed surgery. There was EMG evidence of chronic L4/5 radiculopathy. There is no imaging evidence of nerve

root compression at all proposed surgical levels. There was no radiographic evidence of spinal segmental instability, but there was reported 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. This patient is reported as a current smoker with no documentation of smoking cessation. There are psychological issues noted with no evidence of psychological clearance for surgery. Therefore, this request is not medically necessary.

**Pre-Operative Medical Clearance:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Post-Operative Physical Therapy (24-sessions):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Psychologist/Psychiatrist Evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations Page(s): 100-101.

**Decision rationale:** The California MTUS guidelines recommend the use of psychological evaluation to determine if further psychosocial interventions are indicated. Evidence based medical guidelines support the use of psychosocial screening prior to lumbar fusion surgery. However, this patient is currently noted to be under psychological care. There is no rationale presented to support the medical necessity of this request for psychological/psychiatrist evaluation. Therefore, this request is not medically necessary.