

<b>Case Number:</b>	CM14-0055770		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	03/28/2007
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	04/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/25/2014

### 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. 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 66-year-old male with a reported date of injury on 03/28/2007. The mechanism of injury reportedly occurred when the injured worker was torquing bolts. The injured worker was diagnosed with thoracic or lumbosacral neuritis or radiculitis. Prior treatments were not provided within the medical records. Diagnostic studies included an MRI of the lumbar spine, which was performed on 11/11/2013, which revealed postoperative laminotomies at L5; right posterolateral scar tissue in the thecal sac and encroaching on the thecal sac minimally and encroaching upon the right S1 nerve root in the lateral recess; circumferential disc bulging at L1-2 with mild to moderate central, lateral recess, and foraminal stenosis without direct nerve root impingement; desiccated circumferential bulging disc and prominent broad based disc protrusion at L2-3 resulting in severe central, lateral recess, and moderate bilateral foraminal stenosis; and desiccated circumferential bulging at L4-5 disc with an additional broad based right lateral disc protrusion resulting in severe central and lateral recess stenosis; as well as enhancing soft tissue into the right lateral recess and neural foramen, which either represented previous scar tissue or enhancing acute disc protrusion. A lumbar spine myelogram was performed on 02/20/2014 which revealed status post laminotomies at L4-5 and L5-S1 without overt postsurgical application; multilevel degenerative disc disease showing stability, if not some progression, compared to the prior exam; it was particularly seen at the level of L4-5 where there was a larger posterior disc bulge/right paracentral protrusion which contributed to a moderate to severe central spinal canal stenosis; there was multilevel variable foraminal stenosis seen, the worst being at L4-5. The clinical note dated 01/10/2014 noted the

injured worker had low back and right leg pain. A right L5-S1 microdiscectomy was performed, after which the injured worker's pain completely resolved. The injured worker's low back pain was described as constant and dull with occasional shooting pain down the right lower extremity into the posterior knee. Upon physical examination, the injured worker had decreased range of motion to the lumbar spine, strength was 5/5 in the lower extremities bilaterally, and sensation was intact throughout. Deep tendon reflexes were 2+ at the ankles and knees bilaterally, as well as equal and symmetric. Straight leg raise was negative bilaterally. The provider indicated the injured worker wanted to undergo surgical intervention for the lower back. The clinical note dated 03/03/2014 noted the injured worker had continued low back and lower extremity pain. The injured worker reported his pain was worsening and he was having more pain in the mid back. The provider indicated a large right L4-5 herniated nucleus pulposus with compression on the nerve root and the thecal sac was seen upon CT myelogram, as well as L5-S1 right severe facet arthropathy with nerve root compression. The provider indicated the injured worker would be a candidate for surgery and offered the patient a right L4-5 and L5-S1 POLAr with redo laminectomy and posterolateral instrumentation and fusion. The physician recommended the surgical intervention due to lumbar radiculopathy. The Request for Authorization was dated 03/15/2014.

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

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

**Inpatient right L4-5 and L5-S1 posterior oblique lumbar arthrodesis with redo laminectomy and posterolateral instrumentation and fusion:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines/ Low Back (Acute & Chronic) Procedure Summary Patient Selection Criteria for Lumbar Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM.

**Decision rationale:** The request for inpatient right L4-5 and L5-S1 posterior oblique lumbar arthrodesis with redo laminectomy and posterolateral instrumentation and fusion is not medically necessary. The California MTUS/ACOEM Guidelines state prior to referral for surgery, clinicians should consider referral for a psychological screening to improve the surgical outcomes. The guidelines note direct methods of nerve decompression include laminotomy, standard discectomy, and laminectomy. Surgery may be indicated for patients with severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise; patients with activity limitations due to radiating leg pain for more than 1 month or extreme progression of leg symptoms; and patients with clear clinical, imaging, and electrophysiologic evidence of a lesion; as well as failure to respond to conservative treatment measures. The guidelines indicate patients with increased spinal stability after a surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. Within the provided documentation, there was a lack of documentation indicating the injured worker had significant findings upon physical examination indicative of neural compromise. The injured worker's strength was normal,

sensation was normal, deep tendon reflexes were within normal limits, and the injured worker's straight leg raise was negative. There was a lack of documentation demonstrating the injured worker completed an adequate course of conservative treatment prior to the request. Additionally, there was a lack of evidence of severe and disabling lower leg symptoms in a distribution consistent with the abnormalities seen upon imaging. Therefore, the requested surgical intervention would not be indicated. As such, the request for inpatient right L4-5 and L5-S1 posterior oblique lumbar arthrodesis with redo laminectomy and posterolateral instrumentation and fusion is not medically necessary.