

<b>Case Number:</b>	CM15-0013219		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	06/02/2012
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/22/2015

### 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 was a male, who sustained an industrial injury, June 2, 2012. The injury occurred while working as a Registered Nurse, assisting a patient out of a passenger seat of a small car. The patient weighed between 250-300 pounds. The injured worker felt a pop in the lower back when he lifted the patient out of the car. Past surgical history was positive for L4/5 and L5/S1 discectomy in 1994 or 1995. He was diagnosed with a left L3/4 extraforaminal disc herniation. He underwent left L3/4 microdiscectomy on 5/24/13. The 11/27/13 right shoulder MRI impression documented a significant partial subscapularis tear, supraspinatus tendinosis, and a small anterior glenoid labrum tear. The 11/21/13 lower extremity nerve study was reported as unremarkable. The 9/29/14 lumbar MRI impression documented L5/S1 right moderate foraminal stenosis with some extension of disc material into the inferior foramina which could result in nerve root irritation. There was moderately advanced narrowing of the L4/5 foramina bilaterally with diffuse disc bulge. The 11/18/14 orthopedic consult report cited constant severe thoracic pain, constant moderate to severe lumbar pain extending into his right buttock, hamstring, and down the thigh, constant severe cervical spine pain, and constant moderate to severe right shoulder pain. The patient reported lower extremity numbness when squatting and getting up. Right shoulder exam documented right shoulder tenderness and spasms, significant loss of range of motion in all planes, and positive supraspinatus test. Lumbar spine exam documented right sacroiliac and paraspinal tenderness, marked loss of flexion, extension, and lateral flexion, positive bilateral mechanical and nerve tension signs, and decreased Achilles reflexes bilaterally. Lumbar imaging showed L5/S1 right moderate foraminal stenosis with some

extension of disc material into the inferior foramina, moderate narrowing of the L4/5 foramina bilaterally, and mild disc bulges at L3/4 and L4/5. The treating physician recommended L3/4, L4/5 bilateral decompression, and L5/S1 posterior spinal fusion with bilateral decompression. A right shoulder surgery to repair the labral tear was recommended after lumbar surgery. On December 23, 2014, the utilization review denied authorization for bilateral decompression @ L3-L4, L4-L5, L5-S1 and L-S posterior spinal fusion and right shoulder surgery for repair of labral tear based on an absence of objective clinical evidence and imaging reports. The utilization Reviewer referenced MTUS and ODG guidelines for the decision.

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

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

#### **Bilateral Decompression @ L3-4, L4-5, L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic: Discectomy/ laminectomy

**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. 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. Guideline criteria have not been met. This patient presents with low back and lower extremity radicular pain that has failed to significantly improve despite reasonable conservative treatment. There are clinical exam findings consistent with imaging evidence of potential nerve root irritation at the L5/S1 level. There is no imaging evidence of nerve root compromise at the L3/4 or L4/5 levels. The most recent lower extremity electrodiagnostic study was reported as normal. Therefore, this request for bilateral decompression at L3/4, L4/5 and L5/S1 is not medically necessary.

#### **L5-S1 Posterior Spinal Spinal Fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic: Fusion (spinal)

**Decision rationale:** The California 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 (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, 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. There is no imaging evidence of spinal segmental instability or spondylolisthesis. A psychosocial screen is not evidenced. Therefore, this request for L5/S1 posterior spinal fusion is not medically necessary at this time.

**Right shoulder surgery to repair labral tear:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Shoulder: Surgery for SLAP lesions

**Decision rationale:** The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines recommend surgery for SLAP lesions after 3 months of conservative treatment for Type II or IV lesions, when history and physical exam and imaging indicate pathology. Guideline criteria have been met. There is clinical exam evidence consistent with imaging evidence of the subscapularis tear and small labral tear. However, detailed evidence of up to 3 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the right shoulder and failure has not been submitted. Therefore, this request for right shoulder surgery to repair the labral tear is not medically necessary at this time.