

<b>Case Number:</b>	CM15-0111137		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	11/07/2012
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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 32-year-old male who sustained an industrial injury on 11/7/12. The mechanism of injury was documented as repetitive motion and heavy lifting. Past medical history was positive for a blood clot and depression. The 5/28/13 electrodiagnostic study conclusion documented a normal nerve conduction study and EMG findings suggestive of bilateral chronic active L5 radiculopathy. The 2/17/15 treating physician report cited lower back pain increased after epidural steroid injection without relief. Low back pain was 80% and bilateral leg pain 20%. Physical exam documented paraspinal tenderness to palpation, positive bilateral straight leg raise, decreased range of motion to 80% with pain, sciatic notch tenderness, and decreased L5 sensation. The treatment plan recommended an updated MRI. The 3/12/15 lumbar spine MRI impression documented loss of disc space signal and 3-4 mm disc protrusion at L5/S1 that was not indenting the thecal sac due to a wide anterior epidural space. The central canal and foramina were patent, and facet joints were unremarkable. The other lumbar disc spaces are unremarkable. The 3/31/15 treating physician report cited grade 8-9/10 low back pain with minimal leg pain. Pain radiated down to the feet and toes. Associated symptoms included weakness, giving way, locking, grinding, and swelling of the lumbar spine. He was working full duty and doing stretching exercises at home. Physical exam was documented as unchanged from last visit. The diagnosis was L5/S1 degenerative disc disease. Authorization was requested for L5/S1 anterior lumbar interbody fusion with instrumentation and allograft with bone morpho-genetic protein. Associated surgical requests included post-operative lumbar spine brace and 12 visits of post-op physical therapy. The 5/15/15 utilization review non-

certified the L5/S1 anterior lumbar interbody fusion with instrumentation, allograft and bone morphogenetic protein and associated surgical requests there was no significant focal deficit or evidence of segmental instability or unstable spondylolisthesis.

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

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

**L5-S1 anterior lumbar interbody fusion with instrumentation, allograft, and bone morphogenetic protein:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Fusion (Spinal).

**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 laminotomy, laminectomy, and discectomy 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. Guideline criteria have not been met. This injured worker presents with significant low back pain radiating into both feet and toes with reported weakness and giving way. Clinical exam findings have been consistent with electro-diagnostic evidence of L5 radiculopathy, and imaging evidence of plausible nerve root compression at L5/S1. However, detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no radiographic evidence of spinal segmental instability or discussion of the need for wide decompression which would cause temporary intraoperative instability and necessitate fusion. Additionally, there is no evidence of a psychosocial screening for this injured worker. Therefore, this request is not medically necessary.

**Lumbar Brace for postoperative use:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Fusion (Spinal).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138-139.

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

**12 sessions of postoperative physical therapy at 3 times a week for 4 weeks for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Fusion (Spinal).

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

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