

<b>Case Number:</b>	CM15-0121558		
<b>Date Assigned:</b>	07/09/2015	<b>Date of Injury:</b>	05/24/2012
<b>Decision Date:</b>	08/12/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2015

### 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:

This injured worker is a 46-year-old female who sustained an industrial injury on 5/24/12. Injury occurred while she was pulling a pallet backwards. She slipped and fell onto her right side. Conservative treatment included physical therapy, epidural steroid injection, sacroiliac joint injection, and medications. The 4/17/15 treating physician report indicated that pain initially started only on the right side but had moved to both legs for approximately 4 months. Back pain was worse than left pain, with associated numbness, tingling and weakness. X-rays were taken and reported as normal. Prior imaging in 2013 showed disc annular desiccation with some annular disruption at L5/S1. Updated imaging was recommended. The 5/15/15 treating physician report cited constant low back pain that radiated into both legs. She reported that numbness and tingling had resolved. The pain was rated 6/10 and she is taking ibuprofen and Norco as needed. Physical exam documented normal heel to toe gait, slight forward bent posture, moderate discomfort, and difficulty with transfers. Lumbar range of motion was limited and painful, and Gower's sign was positive. Straight leg raise was negative. Neurologic exam documented 5/5 lower extremity motor strength, +2 and symmetrical deep tendon reflexes, and no sensory loss. Imaging performed 5/11/15 showed a disc annular tear at L5/S1 with all other motion segments appearing normal. The diagnosis was severe discogenic low back pain emanating from L5/S1. The injured worker had failed an adequate trial of conservative treatment. Her condition significantly interfered with her activities of daily living and she was unable to resume her normal activities, including work. Authorization was requested for anterior instrumentation at L5/S1, anterior interbody fusion, L5/S1 intervertebral device with bone morphogenetic protein versus cancellous allograft, assistant surgeon, and pre-operative labs.

The 6/4/15 utilization review non-certified the anterior instrumentation at L5/S1, anterior interbody fusion, L5/S1 intervertebral device with bone morphogenetic protein versus cancellous allograft, and associated surgical requests as there was no progressive neurologic deficit, myelopathy, progressive spinal instability, or anatomic neurologic deficit correlated with imaging. There was also no evidence of psychosocial evaluation. The 6/26/15 treating physician appeal stated that all appropriate guidelines had been met and that a formal psychological evaluation was not required. A psychosocial screen would be a normal part of the surgical candidate process that he would perform.

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

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

**Anterior instrumentation at L5-S1, anterior lumbar interbody fusion, L5-S1 intervertebral device with bone morphogenic protein versus cancellous allograft:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (updated 05/15/15) Online version.

**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 discectomy/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 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 persistent function-limiting lower back pain radiating into both legs. There is imaging evidence of a disc annular tear at L5/S1. Evidence of a reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, clinical exam did not evidence a specific neurologic deficit consistent with L5/S1 radiculopathy. There is no radiographic evidence of spinal segmental instability or findings that would support the need for wide decompression resulting in temporary intra-operative instability. There is no documentation of psychological issues and no evidence that this injured worker had been

referred for psychosocial screening, consistent with guidelines. Therefore, this request is not medically necessary at this time.

**Associated surgical service: assistant surgeon:** 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.

**Pre op labs:** 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.