

<b>Case Number:</b>	CM15-0045505		
<b>Date Assigned:</b>	03/17/2015	<b>Date of Injury:</b>	08/01/2008
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2015

### 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: 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 43-year-old female who reported injury on 11/19/2011. The injured worker reportedly twisted her lower back while setting up tables. The prior therapies included NSAIDs, home therapy, psychotherapy, a TENS unit, cortisone injections, and physiotherapy and acupuncture, without improvement. The injured worker utilized a low back brace and a cane for ambulation. The current medication regimen includes Motrin, Vicodin and a topical cream. The injured worker was noted to undergo an MRI of the lumbosacral spine and a CT of the lumbar spine. The documentation of 02/02/2015 revealed the injured worker had complaints of slight to moderate radiation of pain into the right greater than left leg. The injured worker was utilizing a low back brace with metal stays and a cane for ambulation. The physical examination revealed flexion of her fingers to the middle of her thighs. The injured worker was noted to have minimal flexion with severe pain. Lateral bending and extension provoked moderate pain. There was moderate to severe residual tenderness over the right sacroiliac joint and no tenderness over either sciatic notch. The motor strength was 5/5. Deep tendon reflexes were 2+ bilaterally. There was a positive straight leg raise in the sitting and supine positions. The injured worker underwent x-rays, which revealed a slight amount of disc space narrowing at L3-4 and L4-5, with a moderate amount of hypertrophic spur formation and foraminal narrowing on the right side. The diagnoses included pre-existing degenerative disc disease at L3-4 and L4-5 with rotatory scoliosis; lumbar disc sprain, with disc protrusion 3 mm L4-5 and L5-S1, with foraminal stenosis and nerve root compression; a C9 CAT scan and MRI scan; modic type 2 changes L3-4 and L4-5; and inflammation, right sacroiliac joint. The treatment plan included medications.

Additional recommendation was for an artificial lumbar disc replacement at L3-4 and L4-5, and interbody fusion at L5-S1. A Request for Authorization form was then submitted on 02/09/2015.

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

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

**Foraminotomy:** 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): s 305-307.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines indicate a surgical consultation may be appropriate for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than one month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Clinicians should consider referral for psychological screening to improve surgical outcomes. The clinical documentation submitted for review would not need to include electrophysiologic evidence to support a foraminotomy. The documentation indicated the injured worker had exhausted conservative care; however, the duration of recent conservative care was not provided. There was a lack of documentation of a psychological screening. The request as submitted failed to indicate the levels for the foraminotomy. Given the above, the request for foraminotomy is not medically necessary.

**Microlumbar Laminectomy L3-L4, L4-L5, and L5-S1 with each level Discectomy:** 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): s 305-307.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines indicate a surgical consultation may be appropriate for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than one month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to

benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Clinicians should consider referral for psychological screening to improve surgical outcomes. The clinical documentation submitted for review failed to provide documentation of nerve conduction studies to support the necessity for a discectomy. The documentation indicated the injured worker had exhausted conservative care; however, the duration of recent conservative care was not provided. There was a lack of documentation of a psychological screening. There was a lack of documentation of specific myotomal and dermatomal findings to support the need for a discectomy. The x-ray failed to include that the injured worker had spinal instability at all the requested levels. Given the above, the request for micro lumbar laminectomy L3-L4, L4-L5, and L5-S1 with each level discectomy is not medically necessary.

**Associated Surgical Services: Pre-operative Internal Medicine 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.

**Associated Surgical Services: Hospital Stay 3-5 Days:** 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.

**Associated Surgical Services: Post-operative Physiotherapy 2 x 8 week for Lumbar Spine:**  
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.

**Associated Surgical Services: MRI of the Lumbar Spine:** 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.