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| <b>Case Number:</b>   | CM15-0070772 |                              |            |
| <b>Date Assigned:</b> | 04/20/2015   | <b>Date of Injury:</b>       | 07/18/2013 |
| <b>Decision Date:</b> | 05/19/2015   | <b>UR Denial Date:</b>       | 04/09/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/14/2015 |

### 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 60-year-old male who sustained an industrial injury on 7/18/13. The mechanism of injury was not documented. The 10/9/14 treating physician report cited chronic lower back pain radiating into the left buttock and posterior thigh. Physical exam documented intact lower extremity motor function and sensation. Straight leg raise was positive on the left. There was diffuse tenderness over the lumbosacral junction with mild spasms, restricted range of motion, and tenderness over the left sciatic notch. The diagnosis was lumbago and left greater than right sciatica. Norco was renewed for pain relief. Authorization was requested for a lumbar MRI. The 10/17/14 lumbar spine MRI documented old disc fusions at L4/5 and L5/S1 with no spinal canal stenosis or listhesis. There was mild disc disease at L1/2 through L3/4 with no significant spinal canal stenosis. There was a small far left lateral disc protrusion at L2/3 with no significant effect on the foramen. There was mild foraminal narrowing bilaterally at L2/3 and L3/4. Records indicated that an epidural steroid injection was provided on 1/27/14 with only 2 weeks benefit. The 4/9/15 utilization review non-certified the 4/6/15 request for L3/4 laminectomy and fusion and 2 night inpatient stay as there was very minimal imaging evidence of disc/joint pathology and there was no evidence of instability.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **L3-4 Laminectomy Fusion & Connect to Existing Hardware: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines (ODG).

**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 laminectomy for lumbosacral nerve root decompression. 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 state there is 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. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar 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. 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 patient presents with low back and left lower extremity pain. There are no clinical exam findings consistent with nerve root compression at the L3/4 level. There is no imaging evidence of nerve root compression, disc rupture, or lateral recess stenosis at the L3/4 level. 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. There is no indication that wide decompression would be necessary and result in temporary intraoperative instability. A psychosocial evaluation is not evidenced. Therefore, this request is not medically necessary.

### **3 day Inpatient Stay 2 nights: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Hospital length of stay (LOS).

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

