

<b>Case Number:</b>	CM15-0071846		
<b>Date Assigned:</b>	04/22/2015	<b>Date of Injury:</b>	06/09/2012
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	03/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/15/2015

### 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 62-year-old male who sustained an industrial injury on 6/9/12. The mechanism of injury was not documented. The 10/13/14 lumbar spine MRI impression documented disc desiccation from T9/10 through L5/S1. There was Modic type II endplate degenerative changes at the L2/3 level. At L2/3, there was a 3.4 mm diffuse disc protrusion with effacement of the thecal sac with compromised of the spinal canal. At L3/4, there was a 3.1 mm diffuse disc protrusion with effacement of the thecal sac. Disc material and facet hypertrophy caused bilateral neuroforaminal narrowing that effaced the bilateral L3 exiting nerve roots. At L4/5, there was a 2.8 mm diffuse disc protrusion with effacement of the thecal sac. Disc material and facet hypertrophy caused bilateral neuroforaminal narrowing that effaced the bilateral L4 exiting nerve roots. At L5/S1, there was a 2.5 mm diffuse disc protrusion with effacement of the thecal sac. Disc material and facet hypertrophy caused bilateral neuroforaminal narrowing that effaced the bilateral L5 exiting nerve roots. The 1/9/15 treating physician report cited moderate to severe low back pain with numbness and tingling radiating down the back of his legs to his feet, but not his toes. Medication helped decrease the pain; injections had not helped. Physical exam documented tenderness over L4/5 and L5/S1 bilaterally, mild decrease in range of motion, positive straight leg raise, and normal deep tendon reflexes. The diagnosis included lumbar spine disc herniations from L2/3 to L5/S1. The injured worker was awaiting surgical authorization. Medications were continued including Motrin, Protonix, and transdermal compounds. The 3/3/15 orthopedic surgeon report and appeal noted the injured worker returned with no improvement in his symptoms. Physical exam documented paraspinal tenderness to palpation, normal lumbar

range of motion, normal lordosis and no tenderness over the spinous processes. Lower extremity strength was 5/5, and deep tendon reflexes were +2 and symmetrical. There was diminished sensation over the bilateral L4 dermatomes. There was negative clonus and negative straight leg raise. The diagnosis was lumbar radiculopathy. The treating physician report disagreed with the utilization review denial of the request for L4/5 decompression and fusion on the basis that there was no MRI report of stenosis. He reported that review of the MRI images as read by the radiologist revealed bilateral neuroforaminal narrowing at L4/5 and there was an L4/5 disc collapse, which was causing a vertical stenosis of the foramina at this level. Appeal was requested for an L4/5 decompression and possible fusion. Fusion may be necessary since the vertical stenosis may be required restoring the disc height with an interbody fusion in order to open up the foramina. The 3/13/15 utilization review non-certified the request for L4/5 decompression and fusion as there was no imaging evidence of significant central or foraminal stenosis at L4/5 to warrant urgent surgery, there was no documentation of a thorough neurologic exam or conservative treatment.

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

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

#### **L4-L5 Decompression and Fusion: 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): 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 decompression for lumbosacral nerve root decompression. 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 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 pain with numbness and tingling into both lower extremities. Clinical exam evidence documented L4 dermatomal sensory loss with negative nerve tension signs. There was no motor deficit or reflex change. Imaging documented multilevel disc pathology and bilateral neuroforaminal narrowing with nerve root impingement from L3 to L5. There was no corroborating electro-diagnostic evidence in the available records. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Additionally, there is no documentation of a

psychosocial screening or clearance for surgery. Therefore, this request is not medically necessary.