

<b>Case Number:</b>	CM15-0098442		
<b>Date Assigned:</b>	05/29/2015	<b>Date of Injury:</b>	05/22/2012
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2015

### 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 67-year-old male who sustained an industrial injury on 05/22/12. Injury occurred when he stepped into a pot hole. Conservative treatment had included physical therapy, activity modification, and medications. Records indicated that he had persistent back pain radiating into both lower extremity with numbness, tingling, and weakness. The 12/1/14 pelvis x-ray documented 3 mm L5/S1 degenerative retrolisthesis with no evidence of pars defect and associated disc space narrowing. The 12/02/14 lumbar spine MRI impression documented a transitional lumbosacral junction with L5/S1 counted as the second to the last true disc and the level with trace retrolisthesis. At, L3/4, there was prominent annular bulge and moderate facet hypertrophy causing moderate central stenosis and bilateral foraminal stenosis. At L4/5, there was severe facet and ligamentum flavum hypertrophy with bilateral facet joint effusion with 2-3 mm broad-based disc bulge. This caused triangular deformity of the thecal sac and moderate central canal stenosis. There was a right L4/5 disc protrusion/bulge into the foramina with mild impingement on the exiting right L4 nerve root, and moderate left foraminal stenosis. At L5/S1, there was moderate facet hypertrophy and disc osteophyte complex associated with trace retrolisthesis and broad-based disc bulge causing relatively mild central canal stenosis. The disc bulge contacted the right S1 nerve root without deviating it and there was moderate foraminal stenosis. The 12/16/14 treating physician report cited low back achiness and issues of numbness. He had difficulty with sitting, bending, standing, and walking. Physical exam documented a moderately antalgic gait on the right, and trigger points in the gluteus medius and quadratus lumborum regions bilaterally. Motor testing demonstrated symmetrical 4/5 lower extremity

strength. Sensation was decreased along the lateral aspects of the legs. Lower extremity deep tendon reflexes were symmetrical and 1+. There was positive sacroiliac joint compression test and positive slump test. Imaging was reviewed with right L4 nerve root impingement noted at L4/5 which was consistent with his clinical examination. There was severe degenerative disc disease noted at the L5/S1. The treating physician report stated his agreement with the radiologist's interpretation. Referral for second opinion with a spine surgeon was recommended. The 4/27/15 spine surgeon report cited right upper buttock region pain radiating into the groin with recent onset of numbness. Pain increased with sitting, particularly if he leans off to the right side. Pain was reported 10/10. Symptoms were alleviated with lateral bending to the left. He had tried physical therapy with no success. He had been able to continue working. Physical exam documented some increased pain with internal and external rotation of the hip, and some mild right hip flexion weakness that seemed mostly pain modified. The MRI demonstrated a transitional level. Counting the lowest level as L5/S1, there appears to be a far lateral disc herniation on the right at L2/3 with some foraminal stenosis and disc protrusion at the L3/4 level. The injured worker had on-going symptoms for nearly three years and it was unlikely that further conservative treatment would likely ameliorate his symptoms. Authorization was requested for far lateral decompression right L2/3 and L3/4 and a one day inpatient stay. The 5/5/15 utilization review non-certified the request for far lateral decompression right L2/3 and L3/4 levels and one day inpatient stay as there was a discrepancy of interpretation regarding imaging and involved levels.

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

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

**Far lateral decompression right L2-L3, L3-L4 levels: 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 ½ Lumbar & Thoracic, Discectomy/Laminectomy.

**Decision rationale:** The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiological evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy 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. This injured worker presents with a history of persistent and worsening low back pain radiating into both lower extremity with numbness, tingling and weakness. Clinical exam findings have been reported consistent with L4 nerve root impingement at L4/5 documented on imaging reports. Additional potential for S1 nerve root compression is documented at L5/S1. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The radiologist and treating

physician reading of the MRI differ from the surgeon's report relative to the levels of pathology, even accounting for a numbering difference relative to the lumbosacral transitional vertebrae. Therefore, this request is not medically necessary at this time.

**Associated Surgical Service: Inpatient Hospital stay times 1 day: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back.

**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 ½ Lumbar & Thoracic: Hospital length of stay (LOS).

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