

<b>Case Number:</b>	CM14-0172836		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	02/21/2006
<b>Decision Date:</b>	11/25/2014	<b>UR Denial Date:</b>	10/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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. The expert reviewer is Board Certified in Orthopaedic Surgery, has a subspecialty in Spine Fellowship and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 56-year-old male with a 12/21/06 date of injury, and L4-S1 decompression laminectomy and posterior fusion on 3/6/07. At the time (2/18/14) of request for authorization for L2-3, L3-4 extreme lateral interbody fusion, there is documentation of subjective (low back pain radiating to bilateral buttocks and lateral left leg associated with tingling) and objective (diminished sensation along L3 dermatome and diminished patellar and ankle reflexes) findings, imaging findings (CT myelogram of the lumbar spine (2/8/14) report revealed adjacent segment degenerative changes at L3-L4 resulting in moderate bilateral neuroforaminal stenosis), current diagnoses (lumbar spondylosis), and treatment to date (medications, physical therapy, epidural steroid injection, and facet injections). Medical report identifies that decompression will result in a surgically induced instability. There is no documentation of imaging findings (nerve root compression or MODERATE or greater central canal, lateral recess, or neural foraminal stenosis) at the L2-L3 level.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L2-3, L3-4 Extreme Lateral Interbody 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 Chapter, Discectomy/laminectomy

**Decision rationale:** MTUS reference to ACOEM identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Failure of conservative treatment; and an Indication for fusion (instability or a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminotomy/fusion. ODG identifies documentation of Symptoms/Findings (pain, numbness or tingling in a nerve root distribution) which confirm presence of radiculopathy, objective findings (sensory changes, motor changes, or reflex changes (if reflex present)) that correlate with symptoms, and imaging findings (nerve root compression or MODERATE or greater central canal, lateral recess, or neural foraminal stenosis) in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression. Within the medical information available for review, there is documentation of a diagnosis of lumbar spondylosis. In addition, there is documentation of failure of conservative treatment (medications, physical therapy, and epidural steroid injection). Furthermore, given documentation of subjective (low back pain radiating to bilateral buttocks and lateral left leg associated with tingling) and objective (diminished sensation along L3 dermatome and diminished patellar and ankle reflexes) findings, there is documentation of severe and disabling lower leg symptoms. Lastly, given documentation that decompression will result in a surgically induced instability, there is documentation of an indication for fusion. However, despite documentation of imaging findings (adjacent segment degenerative changes at L3-L4 resulting in moderate bilateral neuroforaminal stenosis), there is no documentation of imaging findings (nerve root compression or MODERATE or greater central canal, lateral recess, or neural foraminal stenosis) at the L2-L3 level. Therefore, based on guidelines and a review of the evidence, the request for L2-3, L3-4 Extreme Lateral Interbody Fusion is not medically necessary.