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| <b>Case Number:</b>   | CM15-0104884 |                              |            |
| <b>Date Assigned:</b> | 06/09/2015   | <b>Date of Injury:</b>       | 10/27/2010 |
| <b>Decision Date:</b> | 07/10/2015   | <b>UR Denial Date:</b>       | 05/01/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/01/2015 |

### 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:

This injured worker is a 35-year-old male who sustained an industrial injury on 10/27/10. The mechanism of injury was not documented. Past surgical history was positive for L5/S1 decompression/laminectomy and fusion with pedicle screws and posterior rods on 3/6/12. The 11/18/14 lumbar spine CT scan impression documented status post L5 laminectomy, partial left L5/S1 facetectomy, and L5/S1 fusion using pedicle screws and posterior road. There was minimal soft tissue density in the left lateral aspect of the thecal sac at L5/S1, which was compatible with epidural fibrosis. There was degenerative disc disease at L4/5 with 2 mm retrolisthesis, likely due to degenerative changes with ligamentous laxity. There was 5-6 mm anterolisthesis of L5 on S1. Findings documented mild disc space narrowing at L4/5 with broad-based posterior disc bulging. The 1/23/15 orthopedic report cited constant moderate low back pain that did not radiate. Pain was exacerbated by exertion and relief with heat and medication. The injured worker moderately limited activity due to pain. Physical exam documented antalgic gait and tenderness over the gluteus medius and minimus, paraspinal muscles, facet joints, and sacroiliac joints. Lumbar flexion and extension were mildly limited with pain. There was normal lower extremity strength and negative nerve tension signs. The history and physical exam were reported consistent with lumbar spondylosis and facetogenic pain. The treatment plan recommended lumbar facet joint injection at L4/5 bilaterally for pain relief, followed by radiofrequency ablation if positive. The 3/12/15 treating physician report indicated that the injured worker was status post bilateral L5/S1 pedicle screw fusion for a grade 2 spondylolisthesis. His medical history was positive for gastrointestinal problems and multiple

surgeries that precluded anterior lumbar interbody fusion. He had developed adjacent disease at L4/5 with some disc bulging with lateral recess syndrome and neuroforaminal narrowing. He had facet blocks at L4/5 and felt great for a few days, followed by return of pain. Subjective complaint included low back pain off to the right side, radicular pain, and right lateral thigh numbness. Conservative treatment included exercise and medications. The injured worker wished to discuss surgical options. The treating physician report recommended bilateral L4/5 nerve decompression, placement of an implant at L4/5, and re-evaluation of the fusion at L5/S1 to make sure it is solid. In the future, if he needs more stabilization at L4/5, a direct lateral interbody fusion would be performed. The 5/1/15 utilization review non-certified the request for requested for bilateral L4/5 nerve decompression with placement of implant at L4/5 as there were no objective findings of functional deficits or neural compromise at the proposed L4/5 level, no documentation of activity limitation, and imaging reports were not corroborated with clinical findings to support the medical necessity of this request.

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

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

#### **Bilateral L4-5 nerve decompression/placement implant at L4-L5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back disorders, surgical considerations.

**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); Disc prosthesis.

**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 electrophysiologic 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. 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. The California MTUS guidelines do not recommend artificial disc replacement and state this should be regarded as experimental at this time. The Official Disability Guidelines do not recommend artificial disc replacement (ADR). Current US treatment coverage recommendations were listed. Indications

for lumbar ADR include primary back and/or leg pain in the absence of nerve root compression with single level disease. Patients exclusions also include spondylolisthesis, stenosis, facet mediated pain, and osteoporosis. FDA approved indications are listed as failure of 6 months non-operative treatment, skeletally mature patient, single disc only, no infection, no sensitivity to implant materials, and no osteoporosis or spondylosis. Guideline criteria have not been met. This injured worker presents with low back radicular pain with right thigh numbness. He is status post L5/S1 decompression and fusion. There are no current clinical exam findings documented. The prior clinical exam on 1/23/15 did not evidence a focal neurologic deficit. The injured worker recently underwent L4/5 facet injections with positive response. There is imaging evidence of degenerative disc disease with mild spondylolisthesis at L4/5 but no documentation of nerve root compression or stenosis. There is no radiographic evidence of spinal segmental instability and no discussion of the need for wide decompression at the L4/5 resulting in temporary intraoperative instability. It is unclear what type of implant is planned. A disc replacement adjacent to a fused spinal segment would represent a hybrid-type complex/construct of which there are no significant long-term large volume medical literature studies at large. A fusion would not be supported due to lack of instability and no evidence of a psychosocial screen. Therefore, this request is not medically necessary.