

<b>Case Number:</b>	CM15-0140569		
<b>Date Assigned:</b>	07/30/2015	<b>Date of Injury:</b>	10/13/2012
<b>Decision Date:</b>	08/28/2015	<b>UR Denial Date:</b>	07/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### 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 70-year-old male who sustained an industrial injury on 10/13/12. Injury was reported when he lifted a client with onset of severe radicular lower back pain. Conservative treatment had included medications, physical therapy, epidural steroid injections, and activity modification. The 8/8/13 lumbar spine MRI impression documented an annular bulge at L5/S1 with a small superimposed posterior central protrusion/extrusion that minimally indented the thecal sac and encroached on the right S1 nerve root. There were degenerative facet joint changes with significant neuroforaminal encroachment bilaterally with near complete effacement of the neuroforaminal fat. There was mild spinal stenosis. The 6/29/15 treating physician report cited lower back pain radiating down both lower extremities from the buttocks to the calf, worse on the right. He reported difficulty in standing, sitting, and walking. Physical exam documented mid-lumbar diffuse tenderness, pain with extension at 20 degrees, 4/5 right dorsiflexion and plantar flexion weakness, absent right ankle reflex, and diminished sensation in the lateral shin, anterior foot, and bottom of the right foot. Surgery was recommended as the injured worker had failed all non-operative therapy. Imaging showed a significant L5/S1 disc extrusion contacting the S1 nerve root, worse on the right. The diagnosis was lumbar disc herniation with radiculopathy and lumbar stenosis. The injured worker had failed all non-surgical treatment. He had a foraminal disc herniation at L5/S1, far lateral, with L5 and S1 nerve root compression causing radiculopathy. He required bilateral L5/S1 discectomy and facetectomy that would create iatrogenic instability and fusion at this level was indicated. Authorization was requested for transforaminal lumbar interbody fusion (TLIF) at L5/S1 with an inpatient stay and lumbosacral orthosis brace. The 7/13/15 utilization review non-certified the TLIF at L5/S1 and associated surgical requests based on an absence of documented spinal

instability. The injured worker appeal letter reported signs/symptoms and clinical findings consistent with radiculopathy. He report that he was very active and treatment should not be influenced by his age. He reported that the fact that his pain was worse at times that others indicated that the area was unstable and would benefit from fusion. Appeal of the denial of the surgery and lumbar brace was requested.

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

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

### **Transforaminal lumbar interbody fusion at L5-S1: Overturned**

**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 Chapter.

**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 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 California MTUS guidelines indicate that lumbar spinal fusion may be considered for patient with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. The guidelines recommend that clinicians consider referral for psychological screening 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. The Official Disability Guidelines do not recommend lumbar fusion for patients with degenerative disc disease, disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or non-specific low back pain. Fusion may be supported for segmental instability (objectively demonstrable) including excessive motion, as in isthmic or degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. Pre-operative clinical surgical indications include all of the following: (1) All physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts including skilled therapy visits, and performance of home exercise program during and after formal therapy. Physical medicine and manual therapy interventions should include cognitive behavioral advice (e.g. ordinary activities are not harmful to the back, patients should remain active, etc.); (2) X-rays demonstrating spinal instability and/or myelogram, CT- myelogram, or MRI demonstrating nerve root impingement correlated with symptoms and exam findings; (3) Spine fusion to be performed at one or two levels; (4) Psychosocial screen with confounding issues addressed; the evaluating mental health professional should document the presence and/or absence of identified psychological barriers that are known to preclude post-operative recovery; (5) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to

surgery and during the period of fusion healing; (6) There should be documentation that the surgeon has discussed potential alternatives, benefits and risks of fusion with the patient. Guideline criteria have been met. This injured worker presents with persistent function-limiting low back pain radiating into the right lower extremity to the calf. Clinical exam findings were consistent with imaging evidence of an L5/S1 disc extrusion with nerve root compression. Detailed evidence of long-term reasonable and/or comprehensive non-operative treatment and failure has been submitted. The treating physician has documented the need for facetectomy that would create temporary intraoperative instability and necessitate fusion. There is no evidence of psychological issues. Therefore, this request is medically necessary.

**Related surgical service: Number of inpatient days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Hospital Length of Stay Section.

**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:** The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for anterior, posterior, or lateral lumbar fusion is 3 days. An inpatient stay following the requested L5/S1 transforaminal lumbar interbody fusion would be supported for up to 3 days. However, the medical necessity of a non-specific request cannot be established. Therefore, this request is not medically necessary.

**Related surgical service: LSO lumbar brace:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138-139.

**Decision rationale:** The California MTUS guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The revised ACOEM Low Back Disorder guidelines do not recommend the use of lumbar supports for prevention or treatment of lower back pain. However, guidelines state that lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. The use of a lumbar support in the post-operative period for pain control is reasonable and supported by guidelines. Therefore, this request is medically necessary.