

<b>Case Number:</b>	CM15-0141332		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	10/30/2010
<b>Decision Date:</b>	09/01/2015	<b>UR Denial Date:</b>	07/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2015

### 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:

This injured worker is a 64-year-old male who sustained an industrial injury on 10/30/10, relative to cumulative trauma as a decontamination/demolition worker. Past medical history was positive for diabetes, hypertension, and elevated cholesterol. He underwent right carpal tunnel release and right cubital tunnel release on 1/12/15. The primary treating physician progress reports note on-going requests for psychological evaluation and treatment. The 6/22/15 initial spine surgery report cited constant low back pain radiating to the legs and feet with episodes of numbness and tingling. Pain increased with prolonged standing, walking, sitting, driving, coughing, sneezing, bending, twisting, and turning. He reported leg weakness that caused him to fall. Conservative treatment included pain medications, heating pad, TENS unit, physical therapy and ambulation with a walker and provided temporary pain relief. Physical exam documented a slow and antalgic gait using a walker, paravertebral muscle tenderness and spasms, painful heel/toe walk, and painful squat. Neurologic exam documented 5/5 lower extremity strain, reduced lower extremity deep tendon reflexes worse on the right, and decreased bilateral S1 dermatomal sensation. Imaging showed mild anterolisthesis (2-3 mm) of L4 on L5 with severe central and bilateral foraminal stenosis due to posterior element hypertrophy at L4/5. There was a large 4 to 5 mm disc bulge at L4/5 with very severe left neuroforaminal narrowing extending into the left foramen and obliterating the fat surrounding the exiting L4 nerve root. At the L5/S1 level, there was a 2 mm disc bulge with mild neuroforaminal narrowing and bilateral facet arthropathy Flexion/extension views showed loss of motion segmental integrity at the L4/5 level. The treating physician discussed the need for wide bilateral decompression that would introduce

instability and necessitate fusion surgery. Authorization was request for inpatient transforaminal lumbar interbody fusion, instrumentation and bone grafting of L4/5, and associated 3-day length of stay and 18 post-op physical therapy. The 5/22/15 utilization review non-certified the inpatient transforaminal lumbar interbody fusion, instrumentation and bone grafting of L4/5 and associated requests as there was no evidence of spinal segmental instability or psychological clearance for surgery.

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

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

#### **Inpatient Transforaminal Lumbar Interbody Fusion, instrumentation and bone grafting of L4-5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 310. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar and Thoracic, Fusion.

**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 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. 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, or surgically induced segmental instability. 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. (2) X-rays demonstrating spinal instability and/or imaging 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) Smoking cessation 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 not been met. This injured worker presents with persistent and function-limiting low back pain radiating into the lower extremities with numbness, tingling and weakness. Clinical exam findings are consistent with imaging evidence of nerve root compression. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The treating physician has documented the need for bilateral wide decompression that would create temporary intraoperative instability and necessitate fusion. However, there is evidence in the medical records of potential psychological issues and no evidence that a psychosocial screen has been provided and the injured worker has been cleared for surgery. Therefore, this request is not medically necessary at this time.

**Associated Surgical Service: 3 days Length of Stay: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 310. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar and Thoracic, Fusion.

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

**Associated Surgical Service: 18 Post operative physiotherapy sessions post fusion (lumbar): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

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