

<b>Case Number:</b>	CM15-0141640		
<b>Date Assigned:</b>	07/31/2015	<b>Date of Injury:</b>	02/16/2011
<b>Decision Date:</b>	09/18/2015	<b>UR Denial Date:</b>	06/26/2015
<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 43-year-old male who sustained an industrial injury on 2/16/11. Injury occurred when he was unloading boxes weighing up to 45 pounds from a trailer. He picked one up from the floor and felt a pop in his lower back. Conservative treatment included physical therapy, lumbar epidural steroid injections, and medications. The 9/24/14 lumbar spine MRI impression documented bilateral L5 spondylolysis with grade 1 (3 mm) anterolisthesis at L5/S1. There was mild left foraminal stenosis at L5/S1 and an annular fissure. There was mild multilevel facet hypertrophy, and mild central canal stenosis at L1/2 and L2/3 due to short pedicles. The 12/24/14 left lower extremity EMG/NCV documented a normal EMG and nerve conduction study of the left lower extremity with no evidence of lumbosacral radiculopathy or peripheral neuropathy. The 6/12/15 treating physician report cited on-going low back discomfort radiating into both legs. Conservative treatment had included 6 epidural steroid injections and physical therapy, none of which had not helped to a significant degree. Physical exam documented mild diffuse tenderness with range of motion discomfort in flexion and extension. Straight leg raise was positive bilaterally. The lower extremity neurologic exam noted decreased sensation in the posterior thighs and calves bilaterally, 5/5 motor function, and trace lower extremity deep tendon reflexes. The diagnosis was spondylolisthesis at L4/5 with bilateral radicular symptoms. He had failed medications, copious amounts of therapy, at least 6 epidural steroid injections, and had been treated by multiple practitioners. He was a candidate for one-level anterior lumbar discectomy and fusion. He was not working because no modified duty is available. Authorization was request for anterior lumbar discectomy and fusion L5-S1, assistant surgeon, pre-operative clearance, and 12 sessions of physical therapy. The 6/26/15

utilization review non-certified the anterior lumbar discectomy and fusion at L5/S1 and the associated surgical requests as the patient did not have a degenerative spondylolisthesis and the bilateral pars defects would not be addressed by an anterior fusion.

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

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

#### **Anterior lumbar discectomy and fusion L5-S1: Overturned**

**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 & 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 recommend lumbar spine fusion as an option for patients with spondylolisthesis (isthmic or degenerative) with instability, and/or symptomatic radiculopathy, and/or symptomatic spinal stenosis when there are on-going symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated e.g. acute traumatic unstable fracture, dislocation, spinal cord injury) and subject to pre-surgical clinical indications below. 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. Spinal instability criteria includes lumbar inter- segmental translational movement of more than 4.5 mm. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability and/or imaging demonstrating nerve root impingement correlated with symptoms and exam findings, spine fusion to be performed at 1 or 2 levels, psychosocial screening with confounding issues addressed, and smoking cessation for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have been met. This injured worker presents with persistent low back pain radiating into both lower extremities. Clinical exam findings were consistent with imaging evidence of plausible nerve root compression. Detailed evidence of long term reasonable and/or comprehensive non-operative

treatment protocol trial and failure has been submitted. There is imaging evidence of a grade 1 (3 mm) anterolisthesis at L5/S1 and pars defects. Anterior fusion is medically appropriate to address radicular symptoms and provide overall stabilization. There are no indications of any psychological issues. Therefore, this request is medically necessary.

**Assistant surgeon:** Overturned

**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, Surgical assistant.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

**Decision rationale:** The California MTUS guidelines do not address the appropriateness of assistant surgeons. [REDACTED] ([REDACTED]) provide direction relative to the typical medical necessity of assistant surgeons. [REDACTED] ([REDACTED]) has revised the list of surgical procedures which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT code 22558, there is a '2' in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

**Pre-operative clearance:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.guideline.gov/content.aspx?id=48408](http://www.guideline.gov/content.aspx?id=48408).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Middle-aged males have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on patient age, long-term use of non-steroidal anti-inflammatory drugs, magnitude of surgical procedure, recumbent position, fluid exchange and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

**Physical therapy 2 times a week for 6 weeks:** Overturned

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

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

**Decision rationale:** The California Post-Surgical Treatment Guidelines for surgical treatment of lumbar fusion suggest a general course of 34 post-operative physical medicine visits over 26 weeks, during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical period. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.