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| <b>Case Number:</b>   | CM15-0147637 |                              |            |
| <b>Date Assigned:</b> | 08/11/2015   | <b>Date of Injury:</b>       | 06/14/1985 |
| <b>Decision Date:</b> | 09/09/2015   | <b>UR Denial Date:</b>       | 07/20/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/29/2015 |

### 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 78-year-old male who sustained an industrial injury on 6/14/95. The mechanism of injury was not documented. The 12/20/13 lumbar spine MRI impression documented mild central canal stenosis at T12/L1 with mild foraminal stenosis and a broad-based disc bulge. At L1/2, there was mild central canal stenosis with retrolisthesis and disc protrusion with mild foraminal stenosis. At L2/3, there was mild central canal stenosis with a disc protrusion and mild foraminal stenosis. At L3/4, there was moderate foraminal stenosis with a broad-based disc protrusion and retrolisthesis. Findings noted a laminectomy at L4/5 with spondylolisthesis and disc protrusion, with moderate to marked foraminal stenosis. At L5/S1, there was a broad-based disc bulge with facet hypertrophy and moderate foraminal stenosis on the left. The 4/30/15 physiatry report cited constant severe neck and lower back pain radiating to the bilateral lower extremities. The injured worker had been on methadone, Lidoderm patches, clonazepam, gabapentin, amitriptyline and Effexor XR. There was a significant component of psychologic overlay to his pain syndrome, with significant imaging findings for neck and back disease. He had recent problems with severe paranoid delusions/confusion requiring a decrease in his Effexor and methadone dosages. His primary care physician was closely involved in the evaluation of his psychotic disorder. He had a family history of 2 children with schizophrenia and bipolar disorder, so this could be a primary psychiatric disease rather than medication side effect. He reported having hallucinations and recently had a psychiatric hospitalization with involuntary hold. He reported multiple falls recently as his house was very crowded, sounded like possible hoarding situation. Cognitive exam documented very tangential thinking, unable to

track well or stay on topic, content focused on delusions, and hallucinations. Physical exam documented slightly flexed posture using a cane, inability to stand up straight, inability to relax back muscles, and major pain behavior. Medication management was documented. The 4/30/15 spine surgery report cited a dominant complaint of severe lower back pain with leg weakness, worse on the right. He was in bed about 20 hours per day. Physical exam documented restricted lumbar range of motion, 4+/5 bilateral knee flexion weakness, 2+ and symmetrical deep tendon reflexes, no clonus, negative Hoffman's, positive bilateral straight leg raise, and numbness over the bilateral lateral thighs, knees, calves, ankles, and feet, including the bottom of the feet. Imaging showed an L4/5 defect, foraminal stenosis and spondylolysis at L4/5, central canal stenosis at L3/4 and L4/5, and left foraminal stenosis at L5/S1. Authorization was requested for posterior spinal fusion, transforaminal lumbar interbody fusion (TLIF), laminectomy at L3/4, L4/5, and L5/S1, and 3-day inpatient length of stay. The 7/20/15 utilization review non-certified the request for inpatient posterior spinal fusion, TLIF, and laminectomy at L3/4, L4/5, and L5/S1 as there was no evidence of degenerative spondylolisthesis or instability, psychosocial screen, or current patient status to support the medical necessity of this request. The 7/25/15 spine surgery letter appeal the denial of lumbar surgery. Spinal instability had been documented on x-rays with a shift of approximately 8-9 degrees anteriorly of L4 on L5 going from extension to flexion. The injured worker's clinical exam was remarkable for dysesthesias and numbness in the bilateral thighs and lateral knees, calves, ankles, and feet. There was decreased sensation over the plantar aspect of both feet, including the heels, more so on the right, which was indicative of neurologic narrowing at multiple locations. Electrical studies evidenced bilateral L5 and right S1 radiculopathy. The intended procedure was a posterior spinal fusion of L4/5 with or without a TLIF with laminectomy of L3/4, L4/5, and L5/S1. On the right, there would be a facetectomy of L4/5 on account of the severe stenosis and prior failed laminotomy. On the left, there would likely be a facetectomy at L4/5 and a foraminotomy at L5/S1. There would be central decompression of L3/4 to accommodate potential TLIF at L4/5 and allow proper decompression of the central stenosis. A fusion of L3/4 or L5/S1 was not intended. The 8/8/15 spine surgery appeal letter stated that the injured worker was most recently seen on 6/17/15, with prior recommendation on 4/30/15 for posterior spinal fusion at L4/5 with decompression of L3/4 through S1, and an interbody fusion at L4/5. There was anatomical and electrical evidence for impingement on the L5 and S1 nerve roots. The injured worker had an L4/5 spondylolisthesis with anterior posterior excursion on flexion/extension films of 8 to 9 mm. With flexion, the anterolisthesis goes to 19 mm, and in extension is 10.5 mm. He reported that there was no past psychological history of substantial concern for this injured worker. He had a history of depression, which was being actively treated by his primary care provider with Effexor. He indicated that there were no obvious psychosocial issues identified by him or his staff that would alter the prognosis. The injured worker clearly had foraminal stenosis bilaterally at L4/5, and positive straight leg raise. A TLIF may not be indicated at the time of surgery but was requested in case it was required.

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

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

**Inpatient Posterior spinal fusion, Transforaminal lumbar interbody fusion, Laminectomy L3-L4, L4-L5, L5-S1: 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) Treatment Index, 11th Edition (web) 2013, Low Back Chapter. Indications for surgery - Discectomy/Laminectomy.

**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. 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 lumbar spine fusion as an option for 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) subject to pre-surgical clinical indications. Spinal instability criteria includes lumbar inter-segmental translational movement of more than 4.5 mm. 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; (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 fully met. This injured worker presents with severe low back pain radiating to both lower extremities with weakness. Clinical exam findings are consistent with imaging and electrodiagnostic evidence of nerve root compromise. There is radiographic evidence of spinal segmental instability at L4/5. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there are significant psychiatric issues identified in the medical records. Guidelines typically require a psychosocial screen and clearance by a mental health professional prior to fusion surgery. Therefore, this request is not medically necessary at this time.

**3 LOS 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, Hospital Length Of Stay (LOS) Guidelines.

**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:** As the surgical request is not supported, this request is not medically necessary.