

Case Number:	CM15-0149267		
Date Assigned:	08/12/2015	Date of Injury:	07/22/2014
Decision Date:	09/17/2015	UR Denial Date:	07/16/2015
Priority:	Standard	Application Received:	07/31/2015

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 53-year-old male who sustained an industrial injury on 7/22/14. Injury occurred when he was loading equipment on his truck and then jumped off the back of his truck. Past surgical history was positive for lumbar laminectomy. The 9/12/14 lumbar spine MRI impression documented bilateral pars defects present at L5 with associated grade 1 anterolisthesis which resulted in severe bilateral neuroforaminal stenosis. At L5/S1, there was bilateral facet arthropathy. The 1/19/15 lumbar spine x-ray impression documented a 3-degree levoscoliosis, degenerative changes at L5/S1 with disc space narrowing, osteophyte formation, and 1.1 cm anterolisthesis of L5 on S1. There was no instability noted with flexion/extension. The 5/4/15 neurosurgical report cited back pain radiating into the buttocks, thighs and calves, right worse than left. The right leg occasionally gave out on him. Physical exam documented moderate to severe mid-lumbar spine tenderness, diminished light touch in the right anterior and bottom of the right foot, absent right ankle reflex, and 4/5 right dorsiflexion and plantar flexion weakness. X-rays showed 12 mm spondylolisthesis at L5/S1 with severe foraminal narrowing. MRI was significant for severe bilateral neuroforaminal stenosis and bilateral facet arthropathy with pars defects. The diagnosis was lumbar spondylolisthesis and lumbar stenosis with radiculopathy. The treatment plan recommended surgical treatment at L5/S1. There was severe foraminal stenosis and the injured worker would require total facetectomy on both sides. There was a pars defect with 12 mm of spondylolisthesis. The injured worker required instrumentation at this level to address adequate lateral recess decompression to address L5 and S1 radiculopathy. The 6/29/15 neurosurgical report cited moderate to severe low back pain radiating down both legs to the calves. The physical exam was essentially unchanged. The

treatment plan recommended bilateral redo decompression at L5/S1. In light of the spondylolisthesis and pars defect, instability was unavoidable at the time of surgery, and therefore fusion was indicated. Authorization was requested for transforaminal lumbar interbody fusion L5-S1; a three day hospital stay, surgical assistant PAC, and an Aspen LSO lumbar brace. The 7/15/15 utilization review non-certified the transforaminal lumbar interbody fusion at L5/S1 and associated surgical requests as there was no frank indication for fusion surgery or x-ray evidence of instability on flexion/extension.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Lumbar interbody 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 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. 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 lower back pain radiating into the lower extremities to the calves, worse on the right, consistent with L5/S1 radiculopathy. Clinical exam findings were

consistent with imaging evidence of plausible nerve root compression. There was radiographic evidence of a 1.1 cm anterolisthesis at L5 on S1, with pars defects. The treating physician opined the need for total facetectomy to adequately decompress the lateral recesses at L5/S1. Detailed evidence of long-term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is no evidence of psychological issues in the medical records. Therefore, this request is medically necessary.

Associated surgical service: 3 day hospital stay: Overturned

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

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 lateral lumbar fusion is 3 days. This request is consistent with guideline recommendations for a 3-day hospital stay. Therefore, this request is medically necessary.

Associated surgical service: Assistant PAC: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. 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 do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) 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 22612, there is a 1 in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

Associated surgical service: Aspen 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.