

Case Number:	CM15-0160137		
Date Assigned:	08/26/2015	Date of Injury:	10/10/1989
Decision Date:	09/29/2015	UR Denial Date:	07/21/2015
Priority:	Standard	Application Received:	08/17/2015

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 73-year-old male who sustained an industrial injury on 10/10/89. Injury occurred relative to a motor vehicle accident while employed as a Deputy Sheriff. Surgical history included L5/S1 laminectomy in 1994. Conservative treatment included medications, chiropractic, physical therapy, and pain management. The 3/12/15 initial spine surgery report cited gradually increasing low back pain radiating down his left leg with tingling into the anterior tibial region. Pain increased with walking and mildly improved with leaning forward. Physical exam documented pain to palpation over the lumbar paraspinal muscles, positive straight leg raise, decreased left anterior thigh and anterior tibial sensation, and antalgic gait. Strength and reflexes were within normal limits. MRI and CT scans were ordered. The 4/15/15 lumbar spine CT scan impression documented advanced degenerative disc disease at L5/S1 with prominent bridging osteophytes. There was lower lumbar moderate foraminal stenosis, most impressive at L5/S1 on the right side. At L4/5, there was moderate canal and foraminal stenosis. The 4/25/15 lumbar spine MRI impression documented degenerative disc disease greatest at L5/S1 with grade I anterolisthesis of L4 on L5 and grade I retrolisthesis of L5 on S1. At L4/5, there was a 4 mm left paracentral disc bulge with significant facet and ligamentum flavum hypertrophy resulting in severe canal stenosis. There was severe left lateral recess narrowing encroaching upon the left descending L5 nerve root, and mild undersurface contact of the exiting L4 nerve roots bilaterally. At L5/S1, there was facet hypertrophy with a minimal disc bulge, mild moderate right neural foraminal narrowing on the right. There was an 8x3cm suprarenal abdominal aortic aneurysm. The 5/14/15 spinal surgery report documented lower back pain radiating down the legs. His

examination is unchanged since his last visit. Authorization was requested for transforaminal lumbar interbody fusion with decompression at L4/5 and L5/S1. The 7/21/15 utilization review non-certified the request for transforaminal lumbar interbody fusion with decompression at L4/5 and L5/S1 as there was no evidence of progressive neurologic deterioration, myelopathy, or progressive spinal instability, no detailed conservative treatment history, and no psychosocial screen. The 7/25/15 treating physician addendum report indicated that the lumbar MRI demonstrated post-operative changes with grade 1 spondylolisthesis at L4/5 and L5/S1 and severe facet arthropathy. Given the neurologic deficit with numbness and tingling and pain distribution, and failure to respond to conservative treatment, a lumbar decompression was recommended. This would require a significant amount of facetectomy with removal of more than 50% of the facet joints at L4/5 and L5/S1 bilaterally. Given the pre-existing spondylolisthesis and extensive surgery decompression with facetectomy, stabilization would be required.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Lumbar Interbody Fusion with decompression at L4-5, 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 in both 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 progressive low back pain radiating down both legs. Clinical exam findings are consistent with imaging evidence of L4 and L5/S1 nerve root compromise. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The treating physician has reported the need for removal of more than 50% of the facet joints bilaterally at L4/5 and L5/S1, which in the presence of grade 1 spondylolisthesis, would create temporary intraoperative instability and necessitate fusion. There are no psychological issues documented. Therefore, this request is medically necessary.