

<b>Case Number:</b>	CM15-0167115		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	12/03/2009
<b>Decision Date:</b>	10/08/2015	<b>UR Denial Date:</b>	08/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2015

### 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 57-year-old female who sustained an industrial injury on 12/3/09. Injury occurred when she fell while trying to stop a patient from falling, and landed on her right buttocks. Past surgical history was positive for gastric bypass on 7/2/09 and right L4/5 microdiscectomy on 6/10/10. Past medical history was positive for anxiety, depression, and stroke/transient ischemic attack. Social history indicated that she was a recovered alcoholic and a current one pack per day smoker. Conservative treatment included medications, acupuncture, epidural steroid injection, and activity modification. The 6/17/15 lumbar spine MRI impression documented mild degenerative changes in the lumbar spine and transitional vertebral anatomy with right hemi-sacralization of L5. At L3/4, there was a small 3 mm diffuse disc bulge with an asymmetric left foraminal component with an annular fissure and mild bilateral facet arthropathy and ligamentum flavum redundancy, resulting in mild left lateral recess and bilateral neuroforaminal stenosis. At L4/5, there was evidence of prior right laminotomy. There was a small disc osteophyte complex with a superimposed small 4 mm AP dimension broad-based right paracentral disc extrusion. There was no significant associated spinal canal stenosis or neuroforaminal stenosis. The 7/7/15 treating physician report cited back pain radiating to both legs, right greater than left. Physical exam documented paraspinal tenderness, and positive bilateral straight leg raise, right greater than left. Motor exam documented 3/5 right knee extension and 4/5 bilateral dorsiflexion weakness. The treatment plan recommended follow-up with the spine surgeon. The 8/5/15 spine surgeon report noted prior recommendation for L3 to L5 instrumented fusion and decompression for spinal stenosis and instability. She had worsening symptoms with right foot drop that had become quite dense. She was having increasing difficulty walking and performing activities of daily living. The recent MRI showed progression of disease

with a spondylolisthesis of L4 on L5 and worsening stenosis. The injured worker was clearly losing function with foot drop and weakness particularly down the right leg, and symptoms on the left as well. The injured worker was a smoker with a history of depression, and those were noted to be confounding variables discussed with the injured worker. Authorization was requested for L3-L5 transforaminal lumbar interbody fusion (TLIF) and L3-L5 posterior spinal fusion with instrumentation, Percocet 10-325mg #100, and Diazepam 5mg #100. The 8/14/15 utilization review non-certified the request for L3-L5 transforaminal lumbar interbody fusion (TLIF) and L3-L5 posterior spinal fusion with instrumentation as there was no documentation of instability or imaging evidence of significant stenosis at either the L3/4 or L4/5 level. The request for Percocet 10/325 mg #100 was non-certified as there was no description of current pain levels or insufficiency of current medication therapy, and the associated surgical request was not medically necessary. The request for Valium 5 mg #100 was non-certified as it appeared to be ordered for post-operative use and the associated surgery was not medically necessary.

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

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

#### **L3-L5 TLIF (Transforaminal Lumbar Interbody Fusion) L3-L5 PSF/PSI: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. 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 not been fully met. This injured worker presents with low back pain radiating down both legs with progressive right foot drop. Clinical exam findings are consistent with imaging evidence of

plausible nerve root compromise. Detailed evidence of long-term reasonable and/or comprehensive non-operative treatment and failure has been submitted. However, there is no radiographic evidence of spondylolisthesis or spinal segmental instability on flexion and extension x-rays. There is no discussion or imaging evidence supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. Potential psychological issues are documented with no evidence of a psychosocial screen. The injured worker is a current smoker with no evidence of 6 weeks of smoking cessation consistent with guidelines. Therefore, this request is not medically necessary at this time.

**Percocet 10-325mg #100: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines support the use of Percocet for moderate to severe pain on an as needed basis. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. On-going management requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. There is no evidence that the injured worker is currently prescribed this medication. It appears that this request is for post-surgical pain management. As the surgical request is not supported, this request is not medically necessary.

**Diazepam 5mg #100: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

**Decision rationale:** The California Chronic Pain Medical Treatment Guidelines indicate that anti-spasticity drugs, including benzodiazepines such as Valium, are used to decrease spasticity in conditions such as cerebral palsy, muscular sclerosis, and spinal cord injuries (upper motor neuron syndromes). Guidelines do not recommend the long-term use of benzodiazepines because long-term efficacy is unproven and there is a risk of dependence. Guidelines limit their use to 4 weeks and indicate that they are the treatment of choice in very few conditions. Long-term use may actually increase anxiety. There is no evidence that the injured worker is currently prescribed this medication. It appears that this request is for post-surgical pain management. The quantity of medication being prescribed is not consistent with guideline recommendations for short term use. As the surgical request is not supported, this request is not medically necessary.