MAXIMUS Federal Services

| Case Number: | CM15-0191907 | | |
|---|---|---|---|
| Date Assigned: | 10/05/2015 | Date of Injury: | 03/22/2013 |
| Decision Date: | 11/13/2015 | UR Denial Date: | 08/31/2015 |
| Priority: | Standard | Application Received: | 09/29/2015 |

## 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: California, Oregon, Washington
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:

The injured worker is a 36 year old male, who sustained an industrial injury on 3-22-13. The injured worker was diagnosed as having lumbar radiculopathy; L4-5 disc protrusion. Treatment to date has included physical therapy; epidural steroid injection lumbar (2013); medications. Diagnostics studies included MRI lumbar spine (4-18-13); EMG-NCV study bilateral lower extremities (1-7-15). Currently, the PR-2 notes dated 8-11-15 indicated the injured worker presents for a follow-up visit. He was last evaluated two weeks prior and lumbar spine surgery was recommended at that time. The provider notes the surgical procedure was denied by Utilization Review. The injured worker reports he is still having back pain radiating to the bilateral thighs. The provider documents a physical examination: "There is tenderness to palpation over the paraspinal musculature. Inspection reveals normal lordosis. Flexion is 60-60 degrees and extension is 25-25 degrees. Right bend is 25 -25 degrees and left bend is 25-25 degrees. There is no tenderness to palpation over the spinous processes. Sensation is diminished over the bilateral L4 dermatomes. There are 2+ reflexes in the patellae and Achilles. Negative Achilles clonus and negative SLRs." The provider notes his plan stating "The Utilization Reviewer denied the procedure because of the amount of translational movement of the lumbar spine was not quantified in the report and this needs to be clarified before determining the medical necessity." The provider's rationale is documented as "The indication for the lumbar fusion is not for current instability. The patient is not currently unstable, and I have mentioned in my previous report the indication for the possibility of a fusion would be only if iatrogenic instability occurs interoperatively if the decompression will cause iatrogenic instability." The

provider further explains the injured worker is not currently unstable, "Therefore, there is no need to have flexion extension x-rays. I indicated the patient for decompression procedure because the patient has radiculopathy that has failed conservative treatment with anti-inflammatories, physical therapy and injection for years and has a neurologic deficit that is concordant with his MRI findings. The indication for the possibility of a fusion may be necessary if such decompression will have to remove more than 50% of the facets in order to adequately decompress the foraminal bilaterally. Therefore, I am requesting authorization for an L4 to L5 decompression with the possibility of a fusion." A MRI of the lumbar spine dated 4-18-13 impression reveals "At L4-L5 there is a 6mm posterior central disc protrusion of latent facet hypertrophy and a neural foraminal narrowing. At L5-S1 there is a 2mm posterior central disc protrusion and a 3mm lateral right disc protrusion with narrowing of the right neural foreamen 2mm posterior central disc protrusion and a 3mm lateral right disc protrusion with narrowing of the right neural foramen." The PR-2 notes dated 7-21-15 are same to similar in nature for documentation of the physical examination. There is submitted medical documentation in the form of an "Intraoperative Neurophysiology" report dated 9-17-15 for a procedure "TLIF L4-L5" as well as billing invoice for "Cell Saver" services for this same date. The operative report dated 9-17-15 was submitted with a procedure documented as L4-5 laminectomy with bilateral medial facetectomy and foraminotomy; L4-5 transforaminal lumbar interbody fusion; insertion of a cage; Use of allograft and autograft; use of microscope; L4-5 posterolateral fusion and L4-5 posterior instrumentation. A Request for Authorization is dated 9-29-15. A Utilization Review letter is dated 8-31-15 and non-certification for L4-L5 Decompression & fusion and Post op Physical therapy 2 times a week for 8 weeks, total visits 16. A request for authorization has been received for L4-L5 Decompression & fusion and Post op Physical therapy 2 times a week for 8 weeks, total visits 16.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**L4-L5 Decompression & fusion:** Upheld

**Claims Administrator 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 and Thoracic Chapter (online version).

**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, Fusion (spinal).

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 states that lumbar fusion, Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptoms. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc

herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm, severe stenosis or psychiatric clearance from the exam note of 7/21/15 to warrant fusion. Therefore the determination is not medically necessary for lumbar fusion.

**Post op Physical therapy 2 times a week for 8 weeks, total visits 16:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary