

<b>Case Number:</b>	CM15-0206303		
<b>Date Assigned:</b>	10/23/2015	<b>Date of Injury:</b>	09/12/2012
<b>Decision Date:</b>	12/04/2015	<b>UR Denial Date:</b>	10/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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 68-year-old female health educator who sustained an industrial injury on 9/12/12. Injury occurred when she fell trying to sit down on a rolling chair that slid from beneath her. Past medical history was positive for hypertension, diabetes, peptic ulcer, chest pain/tightness, heart murmur, stroke, kidney stones, abdominal bleeding, diverticulosis, and shortness of breath. Past surgical history was positive for cervical decompression and fusion in 2008. She underwent bilateral L4/5 lumbar laminotomy, foraminotomy, micro-decompression and micro-discectomy on 2/21/14, a lumbar wound debridement on 3/14/14, and a complete lumbar laminectomy at L4 and a bilateral neuro-foraminotomy L4/5 on 3/28/14. Conservative treatment following surgery included physical therapy, chiropractic, medications, and activity modification. The 7/20/15 lumbar spine MRI impression documented stable post-operative changes of a prior laminectomy with mildly prominent enhancing granulation scar tissue shown dorsal and dorsolateral to the thecal sac. There was a residual but stable 7.0 mm posterior disc protrusion results in mild to moderate bilateral stenosis of lateral recesses with mild to moderate bilateral L4 foraminal narrowing. At L5/S1, there was a 3.0 mm posterior disc protrusion with mild bilateral facet prominence resulting in mild bilateral lateral recess stenosis. The 9/3/15 lumbar spine x-rays documented a grade 1 anterolisthesis of L4 over L5, close to 11 mm, which was reduced by 1-2 mm on flexion views and increased by 1 mm on extension views. There was mild loss of L4/5 disc height and exaggerated lordosis. The 9/25/15 neurosurgical consultation cited grade 8/10 low back pain radiating into the left buttock, posterior thigh and calf with burning in the medial ankle. She had some right lower extremity pain just below the buttock. She

reported occasional left leg numbness on the outside of the lower leg, inside the foot and instep. She reported that her left leg was weaker than her right. She had difficulty climbing stairs and had experienced falls. She was able to sit comfortably for 5 minutes, stand for 5 minutes, walk 100 yards, and ride in a car for only 10 minutes. Activities of daily living aggravated her complaint. Medications were noted to include the anti-psychotic drug Abilify and the anti-depressant Effexor. Physical exam documented restricted and painful lumbar range of motion and antalgic gait. Deep tendon reflexes were +3 at the patella and +2 at the Achilles bilaterally. There was decreased left L4 and right S1 dermatomal sensation. She was only able to perform 2/10 heel stands secondary to dorsiflexion, extensor hallucis longus and tibialis anterior weakness bilaterally. She was only able to do 2/10 toe stands due to low back pain. Straight leg raise was negative. X-rays showed grade 1 anterolisthesis of L4 on L5 with 3 mm translation with flexion/extension views. There were surgical defects of the lamina and posterior of the facet visible at L4. MRI demonstrated grade 1 anterolisthesis of L4 on L5 with large 9 mm disc herniation protruding into the spinal canal with displacement of the thecal sac and multiple nerve roots, severe bilateral foraminal narrowing, large disc protrusion into the foramen, advanced degenerative disc disease with a significant amount of residual disc material at L4/5 and levoscoliosis apex at L3/4. The injured worker had previously been treated with physical therapy and had 3 epidural steroid injections before the lumbar surgery series. She was reported status post prior lumbar laminectomy at L4/5 three times with complications including probable wound infection. The diagnosis included large L4/5 herniated nucleus pulposus bilaterally with cauda equina compression and instability with forward slip. She would need a cardiology clearance prior to surgery. Authorization was requested for redo of the lumbar laminectomy with fusion and spinal instrumentation. The 10/5/15 non-certified the request for redo of the lumbar laminectomy with fusion and spinal instrumentation as there was concern that the injured worker was on Plavix with elevated risk and multiple comorbidities, and a psychosocial screen was not evidenced. The 11/3/15 panel qualified medical examiner's supplemental report documented the clinical impression to include recurrent L4/5 disc protrusion, bilateral foraminal stenosis with intermittent left lower extremity radiculitis. The PQME stated that the repeat x-ray studies demonstrated borderline instability of the L5/S1 interspace and the progression of the L5/S1 disc protrusion with severe central canal stenosis. A trial of lumbar epidural steroid injection was recommended with open consideration for further surgery with respect to the possibility of complete L4/5 decompression with L4/5 fusion augmented with posterior pedicle screw fixation and posterior lateral transverse process fusion. However, this should be undertaken with extreme caution and confirmed by the injured worker's further examination and correlating progression of functional history.

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

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

**Redo lumbar laminectomy with lumbar laminectomy and fusion with spinal instrumentation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Discectomy/laminectomy, Fusion (spinal).

**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 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 not been met. This injured worker presents with persistent low back pain radiating into the left lower extremity to the ankle with occasional numbness and weakness. Functional difficulty was documented in activities of daily living. Clinical exam findings were consistent with imaging evidence of plausible nerve root compromise at the L4/5 level. There is radiographic evidence of spondylolisthesis at L4/5 with 3 mm of segmental translational movement on flexion/extension views. Guidelines would support the medical necessity of fusion following the third discectomy. Evidence of long-term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Epidural steroid injection has been recommended but the injured worker is an insulin-dependent diabetic, which may reasonably preclude use. However, there are potential psychological issues indicated by the injured worker's medication use with no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.