

<b>Case Number:</b>	CM15-0213919		
<b>Date Assigned:</b>	11/03/2015	<b>Date of Injury:</b>	07/22/1997
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	10/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2015

### 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 47-year-old male who sustained an industrial injury on 7/22/97. Injury occurred when he slipped on a wet floor, and twisted his back. He underwent a left L4/5 microdiscectomy in February 1998, artificial disc replacement at L4/5 and anterior interbody fusion at L5/S1 on 5/28/09, and posterior non-segmental fusion, posterolateral arthrodesis, bilateral interlaminar decompression, laminectomy and allograft at L4/5 on 9/17/13. He was diagnosed with a pseudoarthrosis and underwent revision posterior and lateral fusion bilaterally at L4/5 and L5/S1 with instrumentation and bone morphogenetic protein (without retrieval of the artificial disc) on 12/19/14. Past medical history included traumatic right lower extremity/knee injury, gastroesophageal reflux disease, chronic hepatitis C, and depression. The 2/24/15 bilateral lower extremity EMG/NCV study documented evidence of possible active right L4 radiculopathy, chronic left S1 radiculopathy, and generalized polyneuropathy involving the lower extremities, which was motor, sensory, and demyelinating rather than axonal. The 4/6/15 lumbar spine x-ray impression documented disc prosthesis at L4/5 and interbody fusion at the L5/S1 level. Pedicle screws and rods at L4/5 and L5/S1 were in good position. There was no dynamic instability. The 4/6/15 treating physician report indicated that the injured worker was doing better with his back pain and walking better. He had anterior bilateral thigh numbness and issues with sitting tolerance. Physical exam documented 5/5 bilateral lower extremity motor strength and intact sensation bilaterally. X-rays demonstrated intact instrumentation with no lucency at the screw-bone interface. There was adjacent segment degeneration at L3/4. The treatment plan recommended continued lumbar bracing and referral for L3/4 epidural steroid

injection. The 8/26/15 lumbar spine CT scan impression documented a 3.3 cm lytic lesion with ill-defined margins was now seen within the right iliac bone, suggestive of malignancy/metastatic disease. Further evaluation was recommended. There was an interval enlargement of a 0.4 cm sclerotic lesion in the L1 vertebral body. There were mildly enlarged retroperitoneal nodes. There were stable post-fusion changes in the lower lumbar spine. At L3/4, the disc height was normal. There was a small disc bulge, mild facet degeneration, and mild ligamentum flavum hypertrophy. There was mild narrowing of the central canal and lateral recesses, and mild bilateral neuroforaminal narrowing. Findings documented lumbar vertebral alignment and vertical body heights as maintained. The 9/23/15 spinal surgeon report cited mid-lumbar pain, bilateral lower extremity paresthesias, and left anterior thigh and right gluteal pain. CT scan showed retrolisthesis of L3/4, consistent with adjacent segmental degeneration, and stenosis at L3/4. The injured worker had significant and increasing pain that had been resistant to conservative measures including injections, physical therapy, and time. The spine surgeon recommended an L3/4 extreme lateral interbody fusion and a posterior approach with screws and rods from L3-S1. He opined that decompression alone would probably increase his symptoms and given the retrolisthesis at the L3/4 level. At the same time, an abdominal scar revision from the prior anterior lumbar interbody fusion was a possibility. Referral to a plastic surgeon was recommended relative to the abdominal scar. The 9/28/15 pain management report cited grade 3-8/10 low back pain. Pain was characterized as sharp, burning, aching, electricity, pins and needles, constant, and radiating. Lumbar spine exam documented paraspinal tenderness to palpation and decreased range of motion in all planes. Medications included Roxicodone and OxyContin. The treatment plan documented medication management. Authorization was requested on 10/6/15 for lateral interbody fusion at L3/4, revision decompression L3-S1, and medical clearance. The 10/22/15 utilization review non-certified the requests for lateral interbody fusion at L3/4, revision decompression L3-S1, and medical clearance as there were no documented significant exam or imaging findings to support the medical necessity of this surgical request.

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

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

**Lateral interbody fusion L3-L4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**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); XLIF(R) (extreme Lateral Interbody Fusion).

**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 decompression 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. The Official Disability Guidelines state that there is insufficient evidence of the comparative effectiveness of lumbar lateral interbody fusion (LLIF), or extreme lateral interbody fusion (XLIF) or direct lateral interbody fusion (DLIF), versus conventional posterior lumbar interbody fusion (PLIF) or transforaminal lumbar interbody fusion (TLIF). 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 low back pain radiating into the left anterior thigh and right gluteal region with paresthesias. There are no clinical exam findings documented that evidence nerve root compromise and correlate to significant adjacent segment disease at L3/4. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no radiographic evidence of spondylolisthesis or spinal segmental instability on flexion and extension x-rays. There is discussion that adequate decompression combined with retrolisthesis would result in temporary intraoperative instability and necessitate fusion, but this is not fully supported by the radiologist CT scan report. Potential psychological issues are documented with no evidence of a psychosocial screen. There is no compelling rationale presented to support the medical necessity of an extreme lateral interbody fusion in the absence of guideline support and as an exception to guidelines. Therefore, this request is not medically necessary.

**Revision decompression L3-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**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.

**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 decompression 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. Guideline criteria have not been met. This injured worker presents with low back pain radiating into the left anterior thigh and right gluteal region with paresthesias. There are no clinical exam findings documented that evidence nerve root compromise or correlate to significant adjacent segment disease at L3/4 or nerve root compromise at the L4/5 or L5/S1 levels. There is electrodiagnostic evidence of possible acute L4 radiculopathy and chronic S1 radiculopathy. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Potential psychological issues are documented with no evidence of a psychosocial screen. Therefore, this request is not medically necessary.

**Associated surgical service: Medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation  
<http://www.guideline.gov/content.spx?id=48408>.

**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.