

<b>Case Number:</b>	CM15-0089069		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	07/23/2013
<b>Decision Date:</b>	06/22/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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:

The injured worker is a 47-year-old male who sustained an industrial injury on 7/23/13. Injury occurred when he was picking up sponge dough off the floor. Past medical history was reported positive for hypertension. The 10/28/13 lumbar spine MRI revealed spondylotic changes. At L3/4, there was a posterior annular tear within the intervertebral disc with 6 mm posterior disc bulge resulting in moderate left and moderate to severe right neuroforaminal narrowing and facet hypertrophy, moderate to severe central canal stenosis, and bilateral exiting nerve root compromise. At L4/5, there was a posterior annular tear within the intervertebral disc with 5-6 mm posterior disc bulge resulting in moderate to severe bilateral neuroforaminal narrowing and facet hypertrophy, moderate to severe central canal stenosis and bilateral exiting nerve root compromise. At L5/S1, there was moderate to severe bi-neuroforaminal narrowing due to a disc bulge and facet hypertrophy, mild central canal stenosis, and bilateral exiting nerve root compromise. The 8/19/14 lumbar CT myelogram revealed diffuse spondylotic changes with bridging anterior osteophyte formation at L5 to S1 and vacuum disc phenomena at L4 to L5. At L3/4, there was 4-5 mm posterior disc osteophyte complex with calcification of the posterior aspect of the protruding disc and encroachment on the thecal sac and compromise on the exiting right nerve root. At L4/5, there was 30% decrease in disc height, dehydration of the disc, 4-5 mm disc osteophyte complex with encroachment on the thecal sac and compromise on the traversing nerve roots. The 10/7/14 lumbar x-rays documented 5 mm of retrolisthesis of L3 on L4/5 in neutral, which was less pronounced in flexion than extension, indicating some instability at L3/4. The 11/8/14 treating physician report cited severe back and bilateral leg pain and numbness. He

was not able to walk more than one block. The medical necessity of anterior posterior fusion at L3/4 and L4/5 was opined to decompress the nerve roots and cauda equina. He also discussed the need for an extensive amount of decompression that will inherently destabilize the spine. Anterior approach would be performed first followed by a posterior approach later. The progress reports from 11/8/14 to 3/21/15 documented on-going symptoms and failed conservative treatment. The non-authorization of spinal surgery was noted without discussion of psychological issues. The 3/21/15 treating physician report cited a diagnosis of lumbar spinal stenosis at L3/4 and L4/5 with instability. Physical exam documented 2+ lumbar paraspinal muscle spasms and tenderness, loss of lumbar range of motion, 2+ and symmetrical deep tendon reflexes, 4/5 right quadriceps weakness, and decreased sensation over the L3-L4 dermatomes bilaterally. Straight leg raise was positive on the left. The treatment plan indicated that surgery was being scheduled and the treating physician report decided to change it to a posterior approach given his severe stenosis. Additional authorization was requested to include pre-operative cardiology clearance. The 4/14/15 utilization review non-certified the request for anterior lumbar interbody fusion at L3/4 and L4/5 and associated surgical services as there was no documentation of segmental instability or evidence of pre-surgical psychological screening.

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

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

#### **Anterior Lumbar Interbody Fusion at L3-L4 and L4-L5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition, Chapter 7, Independent Medical Examinations and Consultations; and on the Non-MTUS Official Disability Guidelines (ODG), Low Back Chapter.

**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 guidelines recommend decompression for lumbosacral nerve root decompression. MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Before referral for surgery, consideration of referral for psychological screening is recommended 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. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Fusion may be supported for surgically induced segmental instability. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. This patient presents with severe low back and lower extremity pain and numbness. Symptoms were consistent with neurogenic claudication. Clinical exam findings were consistent with imaging evidence of nerve root compromise at the L3/4 and L4/5 levels. Detailed evidence of a reasonable and/or comprehensive non-operative treatment protocol trial

and failure has been submitted. There is radiographic evidence of retrolisthesis at L3 on L4 with some instability on flexion/extension. The medical necessity of wide decompression has been reported that would create temporary intraoperative instability requiring fusion. However, there is no evidence in the medical records of a psychosocial screen or psychological clearance for surgery. Therefore, this request is not medically necessary at this time.

**Inpatient Hospital Stay (3-days): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Hospital length of stay (LOS).

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

**Pre-Operative Cardiac Clearance: 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.