

<b>Case Number:</b>	CM15-0239842		
<b>Date Assigned:</b>	12/16/2015	<b>Date of Injury:</b>	09/07/1982
<b>Decision Date:</b>	01/25/2016	<b>UR Denial Date:</b>	11/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2015

### 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:

This injured worker is a 56-year-old male who sustained an industrial injury on 9/7/82. He reported several take down events and car chases in his 32 years as a police officer. He retired in 2000. Past medical history was positive for arthritis and hypertension. The 5/28/13 lumbar spine MRI documented an 8-9 mm retrolisthesis of L3 with respect to L4, a 3 mm retrolisthesis at L4/5, and a 4 mm retrolisthesis of L2 on L3. The 6/5/15 lumbar spine MRI conclusion documented dextroscoliosis with degenerative disc disease and facet arthropathy and retrolisthesis at L2/3, L3/4, and L4/5. There was canal stenosis that was mild to moderate at L1/2, mild at L2/3, moderate to severe at L3/4, and severe at L4/5. There was neuroforaminal narrowing that was moderate to severe at L2/3, and severe bilaterally at L3/4 and L4/5. Findings documented a 4-5 mm retrolisthesis at L2/3 and L3/4 with 3 mm retrolisthesis at L4/5. The 11/3/15 initial spine surgery report cited increasing left lower leg symptoms and new onset of right leg symptoms, with significant functional limitation. He reported grade 7/10 low back pain radiating into both buttocks and down the lateral aspect of both legs into the dorsal feet, and the right was now more painful than the left. Standing and walking were the most painful. Symptoms improved with sitting or slight forward flexion. He reported left leg weakness around the calf and general right leg weakness. He had been active with physical therapy and chiropractic care without sustained relief. He had received two prior epidural steroid injections that only increased his symptoms. Lumbar spine exam documented restricted range of motion and significant fixed kyphosis of the thoracic spine with positive sagittal balance. Motor strength was 5/5 in all lower extremity muscle groups. Deep tendon reflexes were 1+ and symmetrical

over the lower extremities. He was unable to maintain toe walk on the left. X-rays were obtained and showed a significant congenital fixed kyphosis of the thoracic spine. He had 71 degrees of kyphosis centered at the thoracolumbar junction. He had 13 mm of retrolisthesis at L3/4, as well as extensive degeneration and osteophytes at the L2/3 and L3/4 level. The lumbar MRI was reviewed and showed significant spinal stenosis at L4/5 secondary to ligamentous hypertrophy and retrolisthesis of L4 on L5. He had severe collapse and lateral listhesis of L3 on L4, as well as 14 mm of retrolisthesis. At L2/3, there had near complete loss of disc height and increased kyphosis. He had severe foraminal stenosis at L3/4 and to a lesser extent at L4/5. The injured worker had severe thoracolumbar pathology that he had managed for quite some time despite slow deterioration. Symptoms were now severe and his imaging showed severe pathology at L2/3, L3/4 and L4/5. He had significant stenosis at L4/5 and significant retrolisthesis at L3 on L4, with advanced thoracolumbar kyphosis. He was very limited by pain and had failed nearly all conservative options. Surgical options were discussed including a thoracolumbar fusion into the mid thoracic spine or addressing the most significant pathology at L2/3, L3/4 and L4/5. Authorization was requested for L2/3, L3/4, L4/5 anterior lumbar interbody fusion via direct lateral approach, L2-L5 posterior spinal fusion and instrumentation, L4/5 laminotomy, bilateral foraminotomy, and bilateral partial facetectomy. The 11/25/15 utilization review non-certified the request for L2/3, L3/4, L4/5 anterior lumbar interbody fusion via direct lateral approach, L2-L5 posterior spinal fusion and instrumentation, L4/5 laminotomy, bilateral foraminotomy, and bilateral partial facetectomy as the radiographic and imaging study reported extent of retrolisthesis was different from the provider's interpretation, and there was no reported sensory, motor, or neurologic disturbances or provocative orthopedic testing correlated with radicular symptoms.

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

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

**L2-3, L3-4, L4-5 anterior lumbar interbody fusion via direct lateral approach; L2-5 posterior spinal fusion and instrumentation; L4-5 laminotomy, bilateral foraminotomy, bilateral partial facetectomy:** Overturned

**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-lumbar and thoracic (Acute and chronic): Fusion (spinal).

**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, 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 been met. This injured worker presents with progressively severe low back pain radiating into both lower extremities with symptoms of neurogenic claudication. Clinical exam findings were consistent with imaging evidence of plausible neural compromise with significant degenerative spondylolisthesis and severe thoracolumbar kyphosis. There was significant functional difficulty documented. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is no evidence of psychological issues. Therefore, this request is medically necessary.