

<b>Case Number:</b>	CM14-0137118		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	03/28/2013
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	08/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 45-year-old female uniformed patrol sergeant sustained an industrial injury on 3/28/13. A specific mechanism of injury was not documented. The patient underwent bilateral L5/S1 discectomies on 11/12/13 for a very large bilateral and central disc extrusion. Records indicated the patient had persistent right leg pain and numbness post-operatively. The 6/3/14 lumbar MRI showed a 2 mm L4/5 disc bulge with right annular tear. There was increased signal at L5/S1 that was noted as either a disc herniation or granulation tissue impinging on the thecal sac and encompassing the S1 nerve root sleeves. A gadolinium-enhanced study was recommended to determine if there was a recurrent disc herniation within the granulation tissue. The 7/24/14 treating physician report cited continued and significant back pain and right leg radiculopathy with dense numbness. Functional limitation was noted in sitting for more than 30 minutes or standing more than one hour. She was having progressively worsening symptoms despite multiple exercise sessions and continued home exercise. Medications included Ibuprofen and Gabapentin. Physical exam documented diminished right L5 and S1 sensation, positive straight leg raise on the right, right extensor hallucis longus weakness, and dropped right Achilles reflex. MRI findings were reviewed. The treating physician disagreed with the radiologist and noted a clearly visible recurrent disc herniation at L5/S1. A two-stage lumbar anterior interbody fusion and posterior revision decompression and fusion was recommended. The 8/14/14 utilization review denied the request for lumbar surgery as the cause of the thecal sac impingement and nerve root encroachment was not clearly diagnosed. There was no evidence of instability or that a recurrent disc herniation was present. The 9/2/14 lumbar MRI with gadolinium impression documented post-operative status at L5/S1 disc and laminectomy with a significant amount of epidural granulation tissue surrounding the thecal sac and S1 and S2 nerve root sleeves. There was a right central 4 mm L5/S1 disc protrusion and small superior L5 end-plate Schmorl's node

deformity. There was a 3 to 4 mm inferior L3/4 foraminal disc bulge. The 9/3/14 treating physician report indicated the patient was unchanged with low back pain radiating to the right lateral thigh to the calf with dense numbness. MRI findings showed recurrent disc herniation, some granulation tissue, and up down stenosis affecting the exiting right nerve root. An L5/S1 anterior lumbar interbody fusion was requested to recreate the disc space height and help resolve the stenosis, with posterior decompression to remove any disc material so there will not be any further recurrence of disc herniation.

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

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

**Stage1:L5-S1 anterior lumbar interbody fusion with iliac crest bone graft (ICBG) and cages:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal)

**Decision rationale:** The ACOEM Revised Low Back Disorder guidelines recommend decompression surgery for patients with radiculopathy due to on-going nerve root compression who continue to have significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability has been proven. 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. 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 fully met. There is documentation of a recurrent disc herniation with clinical exam and imaging findings of nerve root compression. The patient has failed comprehensive conservative treatment. There is no current radiographic or clinical evidence of spinal segmental instability. A psychosocial screen is not evidenced. Therefore, this request is not medically necessary.

**Stage 2:L5-S1 revision decompression/fusion with local bone graft and screws:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG,) Low Back - Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal)

**Decision rationale:** The ACOEM Revised Low Back Disorder guidelines recommend decompression surgery for patients with radiculopathy due to on-going nerve root compression who continue to have significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. Lumbar fusion is not recommended as a treatment for spinal stenosis unless concomitant instability has been proven. 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. 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 fully met. There is documentation of a recurrent disc herniation with clinical exam and imaging findings of nerve root compression. The patient has failed comprehensive conservative treatment. There is no current radiographic or clinical evidence of spinal segmental instability. A psychosocial screen is not evidenced. Therefore, this request is not medically necessary.

**Inpatient length of stay for three days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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.

**Assistant surgeon:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Centers for Medicare and Medicaid services, Physician Fee Schedule

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

**Rigid lumbar brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 138-139.

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