

<b>Case Number:</b>	CM15-0178906		
<b>Date Assigned:</b>	09/21/2015	<b>Date of Injury:</b>	02/01/2014
<b>Decision Date:</b>	10/22/2015	<b>UR Denial Date:</b>	08/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2015

### 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 50-year-old male who sustained an industrial injury on 2/1/14. The mechanism of injury was not documented. Conservative treatment included activity modification and medications. Past medical history was negative. Past surgical history was positive for right carpal tunnel release. The 9/3/14 lumbar spine MRI impression documented possible impingement of the right L5 nerve root due to advanced facet arthropathy and diffuse annular bulge at L4/5. At L5/S1, there was 5 mm of retrolisthesis with loss of disc height, diffuse annular bulge, and type II endplate changes. There was advance bilateral neuroforaminal narrowing, moderate facet arthropathy, and mild central canal stenosis with mediolateral narrowing of the spinal canal. The combination of the retrolisthesis, diffuse annular bulge, and facet arthropathy approached the left S1 nerve root in the subarticular recess. The 8/3/15 treating physician report indicated that the injured worker was status post right L4-S1 transforaminal epidural steroid injections on 7/10/15 with 75% relief for 2 weeks. His pain had returned and was constant with no relief. He was using Voltaren gel for pain management as pain medications and NSAIDs caused gastric distress. He had low back pain radiating into both buttocks, thighs and calves, worse on the right, and his right leg occasionally gave out on him. Physical exam documented 4/5 right dorsiflexion and plantar flexion weakness. He had diminished sensation over the right lateral shin and anterior foot. MRI showed a 5 mm L4/5 spondylolisthesis, advanced bilateral neuroforaminal narrowing and moderate facet arthropathy. At L5/S1, there was moderate to severe facet arthropathy and moderate to severe bilateral foraminal narrowing, worse on the right. There was impingement of the L5 and S1 nerve roots. The treatment plan recommended surgical intervention at the L4/5 and L4/5 levels that would cause iatrogenic

instability and necessitate fusion. Authorization was requested for transforaminal lumbar interbody fusion (TLIF) at L4-S1 including an assistant surgeon and a 3-day inpatient length of stay. The 8/24/15 utilization review non-certified the TLIF at L4-S1 and associated requests as guideline criteria had not been met as there were no significant objective findings of L4-S1 radiculopathy, no detailed information regarding failed conservative treatment, no x-ray evidence of instability, and no evidence of a psychosocial screen.

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

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

#### **L4-S1 Transforaminal Lumbar Interbody Fusion: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**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, and 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 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 constant low back pain radiating intermittent both lower extremities to the calves, worse on the right. He reported that his right leg occasionally gave way. Clinical exam findings were consistent with imaging evidence of plausible nerve root compromise at the L4/5 and L5/S1. There was imaging evidence of a 5 mm retrolisthesis at L4/5 but no documentation of instability on flexion/extension films. There is discussion of the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. Evidence of long-term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is no documentation of psychological

issues to be addressed. Therefore, this request is medically necessary.

**Associated Surgical Service: 3 days length of stay:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**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:** The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for lumbar fusion is 3 days. Guideline criteria have been met for inpatient length of stay up to 3 days. Therefore, this request is medically necessary.

**Associated Surgical Service: Assistant Surgeon:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

**Decision rationale:** The California MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT code 22612, there is a 2 in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.