

<b>Case Number:</b>	CM15-0061413		
<b>Date Assigned:</b>	04/07/2015	<b>Date of Injury:</b>	02/13/2013
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2015

### 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 2/13/13. The mechanism of injury was not documented. Past surgical history was positive for anterior interbody fusion at L2-5, posterior revision laminectomy at L3-5, and foraminotomies at L3-5 with posterior segmental instrumentation at L2-5 on 8/28/14. The 10/28/14 treating physician report indicated that the lower seemed to be doing all right. He reported constant and unrelenting thoracic and upper back pain. Lower extremity numbness was improving. He had been using his bone growth stimulator daily and his brace but he may be turning and moving more than he should. Last month, he was involved in a rear-end motor vehicle accident and hit his chest on the steering wheel. X-rays showed lumbar spine was fusing. The treatment plan noted he may be a candidate for thoracic fusion in the future. The 12/30/14 treating physician report cited continued severe thoracic spine pain with pain radiating around his thoracic area and numbness to the chest wall. Imaging in September 2014 demonstrated a large left lateral T5/6 disc extrusion. Due to the significant neurologic symptoms and failure of previous conservative treatment, thoracic posterior discectomy and one-level fusion was recommended. Updated MRI was requested. The 2/5/15 thoracic MRI findings documented a moderate left lateral recess disc extrusion at T5/6 extending 5 mm posterior and migrating beyond the adjacent endplate with a vertical span of 12 mm. There was mild spinal cord flattening to the left without stenosis, and mild facet degenerative joint disease on the right. The 2/11/15 thoracic spine x-rays showed slight dextroscoliosis of the thoracic spine. The 2/11/15 treating physician report indicated that the injured worker was doing very well. He had some lower back pain and lower extremity

radiculopathy/neuropathy. X-rays showed evidence of solid lumbar fusion and physical therapy was requested. He was also diagnosed with thoracic disc herniation at T5/6 with spinal cord compression. Authorization was requested for posterior thoracic laminotomy, microdiscectomy at T5/6, and fusion at T5/6. The 3/9/15 utilization review non-certified the request for posterior laminotomy with discectomy, posterior interbody fusion, and 1-level instrumentation at T5/6. The rationale for non-certification noted no documentation of objective radicular findings in the requested nerve root distribution, no detailed documentation of failed physical modalities, and no evidence of instability or anticipated surgically induced instability.

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

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

#### **Posterior laminotomy with discectomy, posterior interbody fusion, & 1 level instrumentation at T5-6: Overturned**

**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  $L_5/S_1$  Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines recommend lumbar discectomy/laminotomy for carefully selected patients with nerve root compression due to disc prolapse. MTUS guidelines indicate that spinal fusion may be considered for patient 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 discectomy/laminotomy 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 been met. This injured worker presents with thoracic and upper back pain with radicular symptoms into the chest wall. There is imaging evidence of a large disc extrusion at T5/6 with mild cord flattening. There is imaging evidence of prior partial lumbar fusion. Reasonable non-operative treatment trial and failure has been submitted. Therefore, this request is medically necessary.