

<b>Case Number:</b>	CM15-0078038		
<b>Date Assigned:</b>	04/29/2015	<b>Date of Injury:</b>	07/06/2009
<b>Decision Date:</b>	05/28/2015	<b>UR Denial Date:</b>	04/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/23/2015

### 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 55-year-old male who sustained an industrial injury on 7/06/09, relative to cumulative trauma. The 8/21/14 lumbar spine MRI findings documented a 2-3 mm disc protrusion at L4/5 with mild narrowing of the spinal canal and mild to moderate bilateral neuroforaminal narrowing. At L5/S1, there was moderate to severe facet arthritis and mild to moderate narrowing of the neural foramen. Records indicated the injured worker underwent bilateral transforaminal epidural steroid injection at L5 on 7/1/14, and S1 on 12/23/14 with 50% pain relief for 2-3 months. The 3/5/15 lumbar spine x-rays with flexion/extension views showed 7.2 mm retrolisthesis of L2/3 in neutral, 3.8 mm in flexion, and 5.4 mm in extension. There were no other levels of instability noted. The 4/8/15 treating physician report indicated that the injured worker reported a feeling of instability in the upper lumbar spine. His spine would go out of place and he would experience a clicking sensation with severe thoracolumbar paravertebral muscle spasms lasting several hours. This was aggravated by bending, lifting, or sudden movements. He also had intermittent leg pain that was significantly relieved by the right L5 and S1 transforaminal epidural steroid injections. The 3/5/15 and 4/2/15 exam notes indicated that the lumbar clunking sound was worse between 20-30 degrees flexion, and 60-80 degrees of flexion. Femoral nerve stretch was positive. The treatment plan requested authorization for extreme lateral L2-3 interbody fusion with PEEK cage filled with bone morphogenetic protein, right iliac bone graft, right L4-5 and L5-S1 foraminotomy, associated services and inpatient stay for 3 days. The 4/15/15 utilization review certified the request for extreme lateral L2-3 interbody fusion with PEEK cage filled with bone morphogenetic protein, right iliac bone graft, and non-

certified the request for right L4/5 and L5/S1 foraminotomy as the injured worker demonstrated bilateral symptomatology that was relieved by bilateral transforaminal epidural steroid injection and imaging demonstrated bilateral foraminal stenosis. The request for 4-day in-patient stay was modified to 3 days consistent with Official Disability Guidelines.

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

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

#### **Light L4-L5 foraminotomy, QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**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.

**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 foraminotomy 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. Guideline criteria have not been met. This patient presents with low back pain with intermittent bilateral leg pain that had responded to bilateral L5 and S1 injections. Clinical exam findings documented positive bilateral nerve tension signs. Imaging evidence documented bilateral neuroforaminal narrowing at both L4/5 and L5/S1. There is no compelling rationale submitted to support unilateral foraminotomy over bilateral foraminotomy. Therefore, this request is not medically necessary.

#### **Light L5-S1 foraminotomy, QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**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.

**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 foraminotomy 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. Guideline criteria have not been met. This patient presents with low back pain with intermittent bilateral leg pain that had responded to bilateral L5 and S1 injections. Clinical exam findings documented positive bilateral nerve tension signs. Imaging evidence documented bilateral neuroforaminal narrowing at both L4/5 and L5/S1. There is no compelling rationale submitted to support unilateral foraminotomy over bilateral foraminotomy. Therefore, this request is not medically necessary.

**Associated surgical service: Inpatient Stay (days), QTY: 4: Upheld**

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

**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 lateral lumbar fusion is 3 days. The 4/15/15 utilization review modified the request for 4 days inpatient stay, certifying 3 days. There is no compelling reason to support the medical necessity beyond guideline recommendations and the 3 day hospital stay previously certified. Therefore, this request is not medically necessary.