

<b>Case Number:</b>	CM15-0090396		
<b>Date Assigned:</b>	05/14/2015	<b>Date of Injury:</b>	04/19/2006
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	04/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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 59-year-old male who sustained an industrial injury on 4/19/06, relative to heavy lifting. Past medical history was positive for hypertension and benign prostatic hypertrophy. Social history documented the injured worker was a non-smoker. Review of systems noted no psychological symptoms. Past surgical history was positive for anterior lumbar interbody fusion and posterior spinal fusion at L4/5 in 2006. Conservative treatment had included medications, activity modification, physical therapy and epidural steroid injections. The 1/29/15 lumbar spine MRI impression documented status post posterior decompression and fusion at L4/5 without overt post-operative complication. There were multilevel degenerative changes of the lumbar spine, notable for a lessened appearance of the disc protrusion at L3/4 with improved, although persistent left lateral recess stenosis in the setting of moderate central canal stenosis. The 2/2/15 treating physician report cited severe low back pain radiating to both legs in an L4 distribution with complete anesthesia of the left leg in the L4 distribution. Symptoms were progressive and he continued to decline with respect to function, quality of life and activities of daily living. Physical exam documented decreased lumbar range of motion with guarding and significant pain in flexion and extension. He had an antalgic gait, left greater than right hip flexor and quadriceps weakness graded at 4/5, dense left L4 dysesthesias, and absent bilateral patellar reflexes. There was left 4/5 extensor hallucis longus weakness, positive left straight leg raise, and no ankle clonus. The MRI showed a large central disc protrusion at L3/4 above his fusion resulting in severe central canal, lateral recess, and foraminal stenosis with a trefoil thecal sac measuring 5 mm in diameter. There was significant facet arthropathy at

this level. At L5/S1, there was a small broad-based disc bulge with mild facet arthropathy resulting in mild to moderate bilateral foraminal stenosis. The diagnosis was status post anterior/posterior lumbar fusion L4/5, and severe transitional stenosis with disc herniation at L3/4. He had persistent progressive and debilitating lumbago with primary left lower extremity radiculopathy, dysesthesias and weakness, unresponsive to conservative treatment. Authorization was requested for an extreme lateral interbody fusion (XLIF) at L3/4. Records documented certification of the request for XLIF at L3/4 with PEEK cage and BMP (bone morphogenetic protein) on 2/13/15. The 3/30/15 neurosurgical report indicated that the injured worker was status post anterior interbody and posterior spinal fusion at L4/5 with severe transitional stenosis at L3/4. Surgery had been recommended following failure of conservative treatment. Authorization had been received for extreme lateral interbody fusion (XLIF) at L3/4 with BMP but this was never meant as a standalone procedure. The XLIF procedure would improve the foraminal stenosis but was not sufficient to address central canal stenosis. A posterior spinal fusion and laminectomy was required to relieve nerve compression and leg pain, numbness and tingling. Therefore, authorization was requested for posterior spinal fusion, laminectomy at L3/4 with BMP, possible iliac crest bone graft, and hardware revision L4/5. The 4/10/15 utilization review non-certified the request for Posterior spinal fusion and laminectomy at L3-L4 with BMP, possible iliac crest bone graft and hardware revision at L4/5 as there were no current subjective or objective findings and smoking history and psychological clearance were not documented.

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

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

#### **Possible Iliac Crest Bone Graft and hardware revision at L4-L5: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Discectomy/laminectomy; Indications for Surgery.

**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: Fusion (spinal).

**Decision rationale:** The California MTUS guidelines do not provide recommendations for revision lumbar fusion surgeries. The Official Disability Guidelines state that lumbar spinal fusion surgeries use bone grafts, and are sometimes combined with metal devices, to produce a rigid connection between two or more adjacent vertebrae. The use of an iliac crest bone graft is consistent with guidelines. The revision of hardware at L4/5 to incorporate the new fusion at L3/4 is consistent with guidelines. Therefore, this request is medically necessary.

#### **Urgent Posterior spinal fusion and laminectomy at L3-L4 with basic metabolic panel: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Discectomy/laminectomy; Indications for Surgery.

**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, Bone-morphogenetic protein (BMP), Discectomy/ Laminectomy, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines recommend laminectomy for lumbosacral nerve root decompression. MTUS guidelines indicate that lumbar spinal fusion may be considered for patients 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 (ODG) recommend criteria for lumbar laminectomy 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 low back pain radiating to the lower extremities with numbness in an L4 distribution. Clinical exam findings are consistent with imaging evidence of left lateral recess stenosis at L3/4. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. It is reported that an extreme lateral interbody fusion at this level had been certified. The surgeon has documented the medical necessity for posterior laminectomy and spinal fusion to fully decompress the spinal stenosis. There is no evidence of psychological issues. Therefore, this request is medically necessary at this time.