

<b>Case Number:</b>	CM13-0046897		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	01/22/2007
<b>Decision Date:</b>	02/18/2014	<b>UR Denial Date:</b>	10/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/01/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Spine Surgery and is licensed to practice in New York. 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 physician 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:

The patient is a 49-year-old female with an injury date of January 22, 2007. The mechanism is a slip and fall. The patient had a previous T9 to pelvis fusion surgery. The patient documented scoliosis prior to the fusion. The scoliosis was documented at 40° preoperatively and corrected to 27° postoperatively. The patient had a two-level anterior cervical discectomy fusion in 2012. The patient's lumbar surgery from T9 to the pelvis was performed on April 18, 2013 and included multiple levels laminectomies. The patient has chronic back pain with pain down the right lower extremity. A physical exam revealed ambulation with the use of a walker. There was mild atrophy of the right quadriceps compared to the left. Also, there was no specific neurologic deficit as documented. Although the requesting physician states that the patient has weakness in the left legs greater than the right legs, documented neurologic examination reveals very mild bilateral hip flexor knee extension plantar and dorsiflexion weakness of 5 minus over 5. Also, light touch sensation is grossly intact. There is some decreased light touch sensation in the right lower extremity with no particular dermatomal distribution. The patient had x-rays of the lumbar spine that show hardware in place with no evidence of hardware loosening. There was a lateral listhesis noted L3-4. Several EMG nerve conduction studies revealed right-sided L3-4 and 5 radiculopathy. An MRI lumbar spine from February 2013 shows disc space narrowing at L1 to and T12-L1 and L2-3. There is moderate canal stenosis at L3-4, and severe spinal stenosis at L4-5 and L5-S1. The treatment to date has included physical therapy, a back brace, an epidural steroid injection and medication. The patient continues to have pain. The patient has thoracolumbar scoliosis and is status post T9 to the pelvis posterior decompression deformity correction and fusion. The patient has postoperative pain. There is no documentation of hardware failure, failure fusion, instability or fracture. At issue is whether anterior surgery is medically necessary at this time.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior spinal fusion from T12 through S1 through a combined anterior/extreme lateral approach:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Low Back Chapter) AMA Guides (Radiculopathy, Instability).

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

**Decision rationale:** This patient does not meet established criteria for multilevel anterior spinal fusion at this time. There is not a sufficient amount of evidence from any controlled studies that spinal fusion alone was effective for treating any type of acute low back pain. In addition, the medical records do not document hardware loosening, pseudoarthrosis, spinal fracture, dislocation or instability. Imaging studies do not demonstrate evidence of instability. The patient had a previous lower thoracic pelvic fusion with scoliosis correction and osteotomy surgery. The patient is still in the postoperative healing phase in which fusion is taking place. The patient had a lower thoracic to pelvis instrumented fusion. It is not uncommon for patients to experience chronic pain in the postoperative period after this extensive surgery. None of the imaging studies document complications with the instrumentation. There is no documentation of significant postoperative complications. The patient continues to have low back pain. The medical records do not demonstrate any evidence of significant lower extremity radiculopathy. They also do not contain imaging studies that show any correlation between nerve root compression and physical exam findings. There is no documentation of significant postoperative conservative measures except for an epidural steroid injection. More conservative measures are needed at this time. There is no documentation of a significant trial and failure physical therapy. Therefore, established criteria for multilevel anterior spinal fusion surgery are not met.

**Pre-operative clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Low Back Chapter) AMA Guides (Radiculopathy, Instability).

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

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

**A lumbar back brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Low Back Chapter) AMA Guides (Radiculopathy, Instability).

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

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

**A bone growth stimulator- orthofix:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Low Back Chapter) AMA Guides (Radiculopathy, Instability).

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

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

**A TEC system x 14 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Low Back Chapter) AMA Guides (Radiculopathy, Instability).

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

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

**A one week stay at a skilled nursing facility:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Low Back Chapter) AMA Guides (Radiculopathy, Instability).

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

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

**A pre-operative consultation with a vascular surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Low Back Chapter) AMA Guides (Radiculopathy, Instability).

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

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