

<b>Case Number:</b>	CM14-0107671		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	08/01/2000
<b>Decision Date:</b>	11/06/2014	<b>UR Denial Date:</b>	06/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### 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. The expert reviewer is Board Certified in Orthopedic Spine Surgeon and is licensed to practice in Texas. 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/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 injured worker is a 73-year-old male who reported an injury on 08/01/2000 due to cumulative trauma. There were no diagnoses reported. Physical examination dated 05/21/2014 revealed that the injured worker started having problems in 2000, and it has gotten gradually worse, markedly worse over the last 2 years. He was having a hard time walking, with progressive paresis, weakness, radicular pain, and mechanical back pain that can be incapacitating. The injured worker reported the right side was worse than on the left side. He did report that he had some conservative care over the years, but for the most part he has lived with it and dealt with it. The injured worker has not had any injections. The injured worker reported that he has tried some therapy, including chiropractic, in the past, but he has not had any recently. The success with that in the past has not been very good and he is not terribly enthusiastic about trying additional therapy at this time. Medications were tizanidine, triamcinolone acetonide, Nifedipine, carvedilol, bupropion, zolpidem tartrate, omeprazole, ketoconazole, Vicodin, paroxetine, lisinopril, tramadol, gabapentin, and aspirin. Examination revealed 3/5 weakness for the right knee extension, 4/5 weakness for bilateral dorsiflexion, and 4/5 weakness for right plantarflexion, 5/5 strength for left knee extension and left plantarflexion, and 5/5 strength for iliopsoas, quadriceps, and hamstrings. No atrophy was noted. The injured worker was able to ambulate without assistance. Sensory examination revealed significant numbness and tingling that radiated down into both legs, more so on the right than on the left. MRI of the lumbar spine without contrast dated 11/04/2013 revealed diffuse degenerative spine disease, there was neural foraminal stenosis at multiple levels which probably resulted in abutment of several nerve roots. There was moderate central canal stenosis at the L4-5. Treatment plan was for surgical intervention at the L3-5 instrumented fusion and decompression and possible osteotomy at the L3. The request for authorization was submitted.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **L3-L5 Transforaminal lumbar interbody fusion.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official disability guidelines Treatment, Updated 05/12/14, Low Back=Lumbar & Thoracic (Acute & Chronic). Fusion (spinal)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**Decision rationale:** The decision for L3-L5 transforaminal lumbar interbody fusion is not medically necessary. The California MTUS/ACOEM Guidelines state within the first 3 months of after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction is not responsive to conservative therapy (obviously due to a herniated disc) is detected. Referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than 1 or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, failure of conservative treatment to resolve disabling radicular symptoms. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as the second edition of the Minnesota Multiphasic Personality Inventory (MMPI 2). Spinal instability should include lumbar inter-segmental movement of more than 4.5 mm. In addition, clinicians may look for Waddell signs during the physical exam. The injured worker reported he has tried some therapy in the past but was not interested. It was also reported he had never had any injections to his lumbar spine. The neurological examination revealed a decrease in motor strength for the bilateral lower extremities. There were no reports of neurological deficits for sensation or reflexes reported and no examination of the lumbar spine reported. Clinical documentation did not include lumbar instability movement of more than 4.5 mm. Lumbar spondylolisthesis was not reported. Furthermore, there was no psychological screening reported for the injured worker. Based on the lack of documentation detailing a clear indication for an L3-L5 transforaminal lumbar interbody fusion, this request is not medically necessary.

### **PSF (posterior spinal fusion) ;PSI (posterior spinal instrumentation):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official disability guidelines Treatment, Updated 05/12/14, Low Back=Lumbar & Thoracic (Acute & Chronic). Fusion (spinal)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**Decision rationale:** The decision for PSF (Posterior spinal fusion); PSI (posterior spinal instrumentation) is not medically necessary. The California MTUS/ACOEM Guidelines state that spinal fusion is not recommended for patients who have less than 6 months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab preoperative, total disability over 6 months, active psych diagnosis, and narcotic dependence. It was reported that the injured worker was not interested in having physical therapy or chiropractic sessions. The guidelines strongly suggest that there should be preoperative rehab and a psychological evaluation. It was also reported that the injured worker had not had any injections to the lumbar spine or any recent physical therapy. Lumbar spondylolisthesis was not reported nor was instability movement of 4.5mm. Conservative care had not been met. Furthermore, clinical information submitted for review does not provide evidence to justify the decision for PSF (posterior spinal fusion), PSI (posterior spinal instrumentation) is not medically necessary.