

<b>Case Number:</b>	CM14-0170950		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	11/08/2010
<b>Decision Date:</b>	11/21/2014	<b>UR Denial Date:</b>	10/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2014

### 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 54-year-old female who reported an injury on 11/08/2010 due to an unknown mechanism. Diagnoses were spondylolisthesis L4-5 and L3-4 with severe spinal stenosis and left lower extremity radiculopathy; disc degeneration, L5-S1, L4-5, and L3-4; C6-7 disc osteophyte complex with small cervical protrusion, C5-6, and a component of persistent cervical radiculopathy. Past treatments were medications, multiple rounds of chiropractic, acupuncture, physical therapy, and epidural injections in 2011, which only gave her 2 weeks of relief. The injured worker had a MRI of the lumbar spine on 12/02/2013 that revealed a segmentation anomaly of the lumbar spine. There appears to be 6 non-rib bearing lumbar type vertebral bodies with a transitional vertebral body at L6 with large transverse processes that articulate with the sacrum; however, full length scoliosis survey radiographs are recommended to evaluate vertebral body numbering prior to spine intervention. There was a grade I anterolisthesis of L5 on L6 with associated moderate bilateral neural foraminal narrowing and moderate to severe canal stenosis at this level. Minimal anterolisthesis of L4 on L5. In comparison to external MRI, dated 10/18/2013, the degree of anterolisthesis at L4/5 has progressed. The L5-S1 is abnormal with disc desiccation and an annular tear. Surgical history was not reported. The injured worker had a QME on 06/23/2014 that revealed she developed progressive worsening lower back pain. The injured worker had several neurosurgical consultations with different providers that recommended lumbar fusion surgery. The injured worker had also had psychological therapy, for coping with her chronic pain. The injured worker rated her pain an 8/10 on the VAS. Her pain is primarily at the mid line, but does worsen with both back extension and flexion. She reports the pain radiates to the posterior and lateral aspect of the left leg and calf, with subjective weakness in the left leg, especially with walking more than 2 blocks. Examination of the lower back revealed significant tenderness to palpation

of the lower lumbar paraspinal muscles at the levels of L3-5. There was no evidence of significant muscle spasms, but guarding was noted both on lumbar flexion and extension. Flexion was limited to 50 degrees and extension was to 10 degrees. Lateral tilt to both the left and the right were tolerated at 25 degrees, but were painful. Straight leg raising tests were grossly negative bilaterally. Neurological examination, deep tendon reflexes were 2+ in the patella and Achilles bilaterally. Sensory examination, there was decreased sensation to pinprick in the approximate left L5 distribution. Strength was 5/5 in the lower extremities, proximally and distally. Strength was performed 5/5 in the upper extremities. There was no range of motion restriction of the shoulders, elbows, wrists, or fingers. It was reported that "given the progression of anterolisthesis at the lower lumbar level, surgical treatment does appear warranted, especially in the setting of left lower extremity weakness."

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

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

**Anterior Lumbar Interbody Fusion L3-L4, L4-L5, and L5-S1 Followed by Laminectomy Fusion L3-L4, L4-L5, and L5-S1 with Instrumentation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low Back

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

**Decision rationale:** The decision for Anterior Lumbar Interbody Fusion L3-L4, L4-L5, and L5-S1 Followed by Laminectomy Fusion L3-L4, L4-L5, and L5-S1 with Instrumentation is not medically necessary. Spinal fusion in the absence of fracture, dislocation, complications of tumor, or infection is not recommended. Spinal fusion except for cases of trauma related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. The injured worker had flexion/extension radiograph x-ray that was not submitted. It was reported that at L4-L5 there is a clear grade 1 spondylolisthesis with translational instability on flexion/extension views of the x-rays. There is severe stenosis with large facet cyst. MRI on 12/02/2013 revealed grade 1 anterolisthesis of L5 on L6 with associated moderate bilateral neural foraminal narrowing and moderate to severe canal stenosis. The injured worker has not had recent physical therapy reported and it was not reported that she was participating with some kind of exercise or stretching regimen on her own. Medications such as a non-steroidal anti-inflammatory drug were not reported. There were no reports of the use of a back brace for stability. The rationale for a 3 level fusion was not

submitted. The amount of instability of at L4-L5 was not noted. Also, an updated MRI and flexion/extension radiographs were not submitted. Based on the clinical documentation submitted, this request is not medically necessary.

**Assistant Surgeon:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low Back

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**5 Day Inpatient Stay:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low Back

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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