

<b>Case Number:</b>	CM14-0044203		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	05/31/1990
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/11/2014

### 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 Surgery and is licensed to practice in California. 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 58-year-old male who reported an injury on 05/31/1990. The mechanism of injury was not stated. Current diagnoses include status post multiple posterior L3 to S1 fusions, clear-cut pseudoarthrosis at L4-5, and severe stenosis at L2-3. The injured worker was evaluated on 02/25/2014 with progressive weakness in the left lower extremity. Physical examination revealed difficulty standing upright, a significant coronal shift to the left, weakness along the anterior tibialis on the left and diminished left quadriceps reflex. Treatment recommendations at that time included an anterior interbody fusion at L3-4, L4-5, and L5-S1. It is noted that the injured worker underwent an x-ray of the lumbar spine on 03/15/2013, which revealed significant multilevel degenerative joint disease at L3 through S1 with possible spinal stenosis. The injured worker also underwent a CT myelogram of the lumbar spine on 12/13/2013, which indicated complete occlusion of the subarachnoid space at L2-3 with laminectomy at L3, L4, and L5, as well as severe facet arthropathy with foraminal stenosis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 anterior discectomy and fusion with peak instrumentation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for surgery, Low Back: Fusion (spinal) / Discectomy/laminectomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Discectomy/Laminectomy, Fusion.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for a surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, clear clinical, imaging and electrophysiologic evidence of a lesion, and a failure of conservative treatment. The Official Disability Guidelines state prior to a discectomy/laminectomy, there should be objective evidence of radiculopathy. Imaging studies should reveal nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment should include activity modification, drug therapy, and epidural steroid injections. There should also be evidence of a referral to physical or manual therapy, or the completion of a psychological screening. Preoperative surgical indications for a spinal fusion include the identification and treatment of all pain generators, completion of all physical medicine and manual therapy interventions, documented instability on CT myelogram or x-ray, spine pathology that is limited to 2 levels, and a psychosocial screening. As per the documentation submitted, there is no evidence of an exhaustion of conservative treatment prior to the request for an additional surgical procedure. There is also no documentation of spinal instability upon flexion and extension view radiographs at L5-S1 that would warrant the need for a fusion. Based on the clinical information received, the request is not medically necessary.

**L3-S1 posterior fusion, revision laminectomy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for surgery, Low Back: Fusion (spinal) / Discectomy/laminectomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, clear, clinical, imaging and electrophysiologic evidence of a lesion, and a failure of conservative treatment. The Official Disability Guidelines state preoperative clinical surgical indications for a spinal fusion should include the identification and treatment of all pain generators, completion of all physical medicine and manual therapy interventions, documented spinal instability on x-ray or CT myelogram, spine pathology that is limited to 2 levels, and completion of a psychosocial screening. As per the documentation submitted, it was noted on flexion/extension view radiographs of the lumbar spine there was spondylolisthesis at L4-5. However, there is no indication of spinal instability at L3-4 or L5-S1. There is also no mention of an exhaustion of conservative treatment prior to the request for an additional surgical procedure. Furthermore, the

Official Disability Guidelines state preoperative surgical indications for a spinal fusion include spine pathology that is limited to 2 levels. Therefore, the current request cannot be determined as medically appropriate. Based on the clinical information received, the request is not medically necessary.

**Iliac fixation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for surgery, Low Back: Fusion (spinal) / Discectomy/laminectomy.

**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.

**Spinal cord monitoring:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back: intraoperative neurophysiological monitoring & The Center for Medicare and Medicaid Services (CMS).

**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.