

<b>Case Number:</b>	CM14-0113042		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	05/13/2009
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	07/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/18/2014

### 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. 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:

The injured worker is a 54-year-old female who sustained an industrial injury on 5/13/09, relative to a slip and fall. She underwent an anterior cervical discectomy and fusion at C4/5 and C5/6 on 9/27/10, an L3/4 to L5/S1 fusion on 8/27/12, and left shoulder arthroscopic surgery on 12/17/13. The May 2013 electrodiagnostic study showed no evidence for radiculopathy, plexopathy, myopathy, or peripheral neuropathy. Records documented a May 2013 lumbar spine CT scan that showed extensive loss of disc space at L4/5 and L5/S1. X-rays at that time showed extensive spine surgery with hardware and PEEK-type prosthesis to help fuse the interbodies of the penultimate disc space and the one above. The treating physician report stated that in looking carefully, there were six lumbar vertebrae of which L6/S1 does not move based on the lateral view. He stated that if one counted from the bottom, it was the 3-4 and 4-5, but it is really 4-5 and 5-6. L6/S1 was basically a vestigial disc with very little disc space and probably did not move. There was no spondylolisthesis. Hardware was intact with no evidence for breakage. There was little evidence of bone in the latter gutter as far as the posterolateral fusion was concerned. Anterior interbody fusion appeared solid between the penultimate space and the one above. The 6/24/14 treating physician report cited chronic intermittent grade 7/10 low back pain and bilateral leg pain. Physical exam documented normal gait, bilateral lumbar paravertebral muscle tenderness, and no paravertebral muscle spasms. There was back pain with right or left lateral rotation. Straight leg raise was positive bilaterally. There was normal lower extremity strength and sensation. Lumbar range of motion was restricted. The diagnosis included lumbosacral spondylosis without myelopathy and muscle spasms. A number of concerning

issues were raised. Weaning of the morphine equivalent dose to below 120 was in process, but the injured worker stated she could absolutely not decrease her OxyContin due to pain. She requested a Demerol injection as her pain had escalated due to continued decreases in medications. Various other treatment modalities were discussed. Medications were prescribed to include capsaicin, ketorolac, OxyContin, gabapentin, hydrocodone, Sentra PM, and trazodone. The 6/25/14 orthopedic spine surgery letter appealed the denial for extension of fusion to L5/S1 posteriorly and fusion of both sacroiliac (SI) joints with spinopelvic fixation. This was an unusual construct but the clinical exam, as well as the CT scan of the pelvis and lumbar spine, demonstrated a combination of severe degeneration at L5/S1 as well as sacroiliac arthropathy, with all the signs of joint degeneration. He did not want to perform multiple procedures as performing it all in one sitting could be done with the same incision and result in the best outcome. The 7/11/14 utilization review non-certified the request for extension of the fusion to L5/S1 as neurologic compromise was not well documented, there were clearly multilevel levels of involvement in the injured worker's spine pathology, and instability was not documented. The request for SI joint fusion was non-certified as there was no definitive evidence that the SI joints were the origin of pain, and there was no evidence of SI joint diagnostic injections. The 4-day inpatient stay was non-certified, as the associated surgical requests were not found to be medically necessary.

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

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

**L5-S1 Posterior Fusion:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines state there was no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Guidelines state that spinal fusion is recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. 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 not been met. This patient presents with low back and bilateral lower extremity pain. There is clinical exam evidence of limited motion and positive nerve tension signs. Imaging evidenced extensive loss of disc space

at the L4/5 and L5/S1 levels. However, there is no radiographic evidence of spinal segmental instability. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There are potential psychological issues noted and no evidence of psychosocial screening or psychological clearance for surgery. Therefore, this request is not medically necessary.

**Inpatient Stay (4 days):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.

**Fusion of Both Sacroiliac Joints with Spinopelvic Fixation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip & Pelvis Chapter, SI Joint Fusion.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis (Acute & Chronic) Sacroiliac Joint Infusion.

**Decision rationale:** The California MTUS guidelines do not address sacroiliac (SI) joint fusion. The Official Disability Guidelines (ODG) do not recommend sacroiliac joint fusion except as a last resort for chronic or severe sacroiliac joint pain. Guidelines indicate that the diagnosis of sacroiliac joint pain is controversial and difficult to make accurately, and the evidence base for fusion to treat this vague diagnosis is weak and conflicted. Indications for SI joint fusion include post-traumatic injury of the SI joint or all the following: failure of non-operative treatment, chronic pain lasting for years, diagnosis confirmed with Intrarticular SI joint injections under fluoroscopic guidance with positive response to the injury noted and patient had a recurrence of symptoms after the initial positive, pre-operative and post-operative general health and function assessed, and medical records and plain radiographs reviewed retrospectively to determine the clinical and radiographic outcome. Guideline criteria have not been met. This patient presents with low back and bilateral leg pain. There is no significant combination of clinical exam findings documented and imaging evidence in the file reflective of significant sacroiliac joint pathology. The orthopedic surgeon reported imaging evidence of sacroiliac joint arthropathy on pelvic CT scans not found in the available records. There is no documentation of a positive diagnostic injection test. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the sacroiliac joints and failure has not been submitted. Therefore, this request is not medically necessary.