

<b>Case Number:</b>	CM14-0198748		
<b>Date Assigned:</b>	12/09/2014	<b>Date of Injury:</b>	11/18/2013
<b>Decision Date:</b>	01/29/2015	<b>UR Denial Date:</b>	11/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2014

### 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 62-year-old smoker who reported an injury when her legs gave out as she was getting out of a van on 11/18/2013. On 05/07/2014, her diagnoses included traumatic aggravation of severe degenerative disc disease L4-5, L5-S1, history of MI with chest pain, on nitroglycerine, and medication controlled asthma. Her complaints included lower back pain which was exacerbated with bending, lifting, and stooping, numbness and tingling in both extremities, and difficulty sleeping due to lower back pain. Her pain limited her ability to perform her ADLs. On examination, there was tenderness to the paralumbar musculature bilaterally of the lower back, and severe pain to the point of withdrawal with any attempts at lumbar extension which tended to maximize her symptoms. She had a bilateral positive straight leg raising test with sensory deficits at both L5 and S1 bilaterally. There was pain at the bilateral sciatic notches. She had absent ankle reflexes. She had a positive Lasegue's sign bilaterally. X-rays of the lower back revealed obliteration of the L4-5 and L5-S1 disc space with extensive osteophyte formation surrounding the disc spaces. It was worse at L4-5 with a very large osteophyte. There was also narrowing at the L3-4 disc space. There was no segmental instability. An MRI on 12/17/2013 revealed at L5-S1 level, a 3 mm disc bulge abuted bilateral L5 nerve roots and contributed to mild right and moderate left foraminal narrowing. At L4-5, a 4 mm central disc protrusion contributed to mild right and moderate left foraminal narrowing. Electrodiagnostic testing on 09/17/2014 revealed chronic L5 nerve root irritation on the left side, atrophy of the right extensor digitorum brevis muscle, no evidence of entrapment neuropathy on the left peroneal or bilateral tibial nerves, and no evidence to support distal peripheral neuropathy in the lower extremities. It was noted on 10/24/2014 that she had ongoing persistent lower back pain and sciatica, despite physical therapy, chiropractic treatment, acupuncture, and epidural injections. She was presented with her options, which were live with the pain or

surgery. She reportedly opted for the surgery. A Request for Authorization, dated 11/08/2014, was included in this injured worker's chart.

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

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

#### **Laminectomy posterios spinal fusion with instrumentation on post lateral interbody fusion L4-5 L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307; 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic, Spinal Fusion

**Decision rationale:** The request for laminectomy posterios spinal fusion with instrumentation on post lateral interbody fusion L4-5 L5-S1 is not medically necessary. The California ACOEM Guidelines note that within the first 3 months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy, and obviously due to a herniated disc, is detected. Disc herniation may impinge on a nerve root, causing irritation, back and leg symptoms, and nerve root dysfunction. The presence of a herniated disc on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disc herniations that apparently do not cause symptoms. Some studies suggest that pain may be due to irritation of the dorsal root ganglion by inflammogens released from a damaged disc in the absence of anatomical evidence of direct contact between neural elements and disc material. Therefore, referral for surgical consultation is indicated in 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 month or extreme progression of lower leg symptoms, clear, clinical imaging and electrophysiological evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and especially expectations, is very important. Patients with acute low back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standardized tests, such as the MMPI-2. With or without surgery, more than 80% of patients with apparent surgical indications eventually recovery. Although surgery appears to speed short to mid-term recovery, surgical morbidity and complications must be considered. Surgery benefits fewer than 40% of patients with questionable physiologic findings. Moreover, surgery increases the need for future surgical procedures with higher complication rates. In good surgery centers, the overall incidence of complications from first time disc surgery is less than 1%. However, for older patients and repeat procedures, the rate of complications is dramatically higher. Patients with comorbid

conditions, such as cardiac or respiratory disease, may be poor candidates for surgery. Comorbidities should be weighed and discussed carefully with the patient. Except for cases of trauma related spinal fracture or dislocation, fusion of the spine is not usually considered during the first 3 months of symptoms. Patients with increased spinal instability 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. A study has shown that only 29% assessed themselves as "much better" in the surgical group versus 14% "much better" in the nonfusion group (a 15% greater chance of being "much better") versus a 17% complication rate, including 9% life threatening or reoperation. The preoperative clinical surgical indications for spinal fusion in the Official Disability Guidelines recommend that all of the following should be included: (1) all pain generators are identified and treated, (2) all physical medicine and manual therapy interventions are completed, (3) x-rays demonstrating spinal instability and/or myelogram, CT myelogram, or discography, and MRI demonstrating disc pathology correlated with symptoms and exam findings, (4) spine pathology limited to 2 levels, (5) psychosocial screen with confounding issues addressed, (6) for any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least 6 weeks prior to surgery and during the period of fusion healing. On 05/07/2014, it was noted that this injured worker was having second thoughts concerning back surgery. On 06/26/2014, it was noted that the risks and details of the surgery were discussed with her, but she did not want the fusion. Her x-rays clearly showed that there was no segmental instability. There was no evidence in the submitted documentation that this injured worker had gone through a psychosocial screening or had been administered any psychometric instruments. Additionally, her cardiac and respiratory comorbidities were not addressed in the documents submitted for review. The clinical information submitted failed to meet the evidence based guidelines for the requested procedure. Therefore, this request for laminectomy posterior spinal fusion with instrumentation on post lateral interbody fusion L4-5 L5-S1 is not medically necessary.

**5 Day in patient hospital stay:** 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.

**Assistant surgeon:** 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.

**Medical clearance:** 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.

**Commode:** 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.

**Front wheel walker:** 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.

**Custom molded TLSO brace:** 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.