

<b>Case Number:</b>	CM14-0204704		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	11/23/1994
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	11/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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: 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 58-year-old female who reported injury on 11/23/1994. The mechanism of injury was not provided. There was a Request for Authorization submitted for review. The injured worker was noted to be status post L4-S1 fusion. Surgical intervention was in 2001. The documentation of 10/15/2014 revealed the injured worker had complaints of ongoing mid back pain and moderate low back pain with radiation of pain to the left lower extremity with numbness and tingling. Conservative care was not provided. A request for weight loss program was denied. The injured worker x-rays of the lumbar spine on 08/18/2014, which revealed mild to moderate levoscoliosis of the thoracolumbar spine centered at L1 with Cobb angle measurements of 25 degrees, an interbody fusion procedure was present at L4-5 and L5-S1; there was a very slight ventral spondylolisthesis of L2 on L3; there was right sided intervertebral disc space narrowing at T11-12, T12-L1 and L1-L2 and L2-3 and left sided intervertebral disc space narrowing at L3-4 related to scoliosis and degenerative spondylosis; there was facet hypertrophy at L2-3 through L5-S1. The injured worker underwent a CT scan of the lumbar spine on 08/18/2014, which revealed minimal posterior protrusion of calcified disc osteophyte complex at T11-12, mild right posterior protrusion of calcified disc osteophyte complex at T12-L1, minimal disc bulge at L1-2 and mild to moderate central stenosis with spondylolisthesis at L2 on L3; moderate central stenosis at L3-4 with facet stenosis and postsurgical changes at L4-5 and L5-S1 with mild to moderate levoscoliosis of the thoracolumbar spine. The physical examination revealed the injured worker's BMI was 40.1. The injured worker had tenderness of the paralumbar muscles bilaterally with 2+ spasms and tenderness. There was tenderness in the

sciatic notch. There was decreased range of motion limited by pain in all direction. The straight leg raise in the supine position was positive on the left at 45 degrees. The deep tendon reflexes were 0/4 bilaterally in the patella and Achilles. The lower motor extremity strength was 5/5 bilaterally with the exception of 5-/5 on the left for the knee extensors. There was diminished sensation at L3 and L4 dermatomal distribution to pinprick on the left. The diagnoses included status post lumbar fusion at L4-S1 performed in 2001, adjacent level disease at L1-L4, thoracic spine herniated nucleus pulposus at T5-6, T6-7 and T7-8, progressive pain related to disc pathology per MRI of the thoracic spine at T1-2, T5-6, T11-12 and T12-L1, as well as T2-10 scoliosis; T12-L1 with a 4 mm right paracentral broad based disc bulge, L2-L3 with a 4 mm central broad based disc bulge, L3-4 with a 7 mm right foraminal broad based disc bulge, L5-S1 with a 4 mm to 5 mm broad based disc osteophyte complex per MRI 07/14/2014, mild to moderate levoscoliosis with apex at L1 with a 25 degree Cobb angle per x-ray 08/20/2014, right sided disc space narrowing from T11-12 to L2-3 per x-ray dated 08/20/2014, and left sided disc space narrowing at L3-4 per x-ray dated 08/20/2014. A request was made for a thoracolumbar spine posterior fusion from T4-S1. Additionally, a consultation with a weight loss treatment program with options was requested.

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

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

#### **Thoracolumbar Spine Posterior Fusion from T4 Through S1 with 1-3 Day Inpatient Hospital Stay: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Hospital Length of Stay

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and 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 and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, 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. Clinicians should consider referral for psychological screening to improve surgical outcomes. There would be no need for electrophysiologic evidence as this request was for a fusion. There were objective findings upon physical examination. There were x-rays that revealed the injured worker has slight spondylolisthesis of L2-3, with a mild to moderate levoscoliosis at L1 and a 25 degree cobb angle with right space disc narrowing from T11-T12 to L2-L3 as well as left sided

disc space narrowing at L3-L4. However, there no documented instability at the requested levels. There was noted to be no significant stenosis at the level of T11-L1. There was minimal disc bulge without significant stenosis at L1-2. There was recess stenosis at L2-3 with a slight ventral spondylolisthesis of L2 on L3 without spondylosis. There was a lack of documentation indicating the injured worker had undergone a psychological evaluation to support a clearance for the surgical fusion. The Official Disability Guidelines indicate that for a posterior thoracic fusion, the median quantity of days is 6 days. The requested hospital stay would be supported, if the surgical intervention was supported. Given the above, the request for a thoracolumbar spine posterior fusion from T4 through S1 with 1-3 day inpatient hospital stay is not medically necessary.