

<b>Case Number:</b>	CM15-0009642		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	12/01/2010
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	12/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2015

### 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: Minnesota, Florida  
 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 68 year old female, who sustained an industrial injury on December 1, 2010. The diagnoses have included repetitive strain in the bilateral upper extremities, cervicgia, and lumbago. Treatment to date has included left wrist surgery in 2012, cervical surgery, cervical epidural injections, and medications. Currently, the injured worker complains of intermittent pain in the cervical spine with radiation of pain into the upper extremities, migraine type headaches, low back pain with radiation to the lower extremities, and difficulty sleeping. The Primary Treating Physician's report dated October 22, 2014, noted palpable tenderness with spasm in the cervical spine, and palpable paravertebral muscle tenderness with spasm in the lumbar spine. A seated nerve root test was positive with standing flexion and extension of the lumbar spine guarded and restricted. The Physician noted tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot, and L5-S1 dermatomal patterns. On December 26, 2014, Utilization Review non-certified a L3 to S1, possible L2-3, posterior lumbar interbody fusion (PLIF) with possible reduction of listhesis, front wheeled walker, ice unit, bone stimulator, thoracolumbosacral orthosis (TLSO), 3-1 commode, inpatient stay two to three days, medical clearance with an internist, and a surgical assistant. The UR Physician noted that with the radiographic report of the imaging report documenting no facet hypertrophy, and no explanation from the treating physician that adequate decompression would require complete facetectomies creating instability, the guidelines were not satisfied, and therefore the surgery and the associated requests were all non-certified. The MTUS American College of Occupational and Environmental Medicine (ACOEM) Guidelines was cited. On January 16, 2015, the injured

worker submitted an application for IMR for review of a L3 to S1, possible L2-3, posterior lumbar interbody fusion (PLIF) with possible reduction of listhesis, front wheeled walker, ice unit, bone stimulator, thoracolumbosacral orthosis (TLSO), 3-1 commode, inpatient stay two to three days, medical clearance with an internist, and a surgical assistant.

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

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

**L3 to S1, possible L2-3, posterior lumbar interbody fusion (PLIF) with possible reduction of listhesis:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 306, 307, 310.

**Decision rationale:** The injured worker is a 68-year-old female. Per primary treating physician's progress report dated 6/18/2014 the injured worker was complaining of constant pain in the cervical spine radiating into the upper extremities associated with headaches, tension between the shoulder blades, and constant low back pain with radiation into the lower extremities. There was tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot, L5 and S1 dermatomal patterns. There was 4/5 strength in the extensor hallucis longus and ankle plantar flexors. Ankle reflexes were asymmetric. October 16, 2013: MRI scan of the lumbar spine revealed L4-5: Dehydration of the disc; Schmorl's node in the anterior/inferior aspect of L4; 4 mm posterior disc protrusion with an annular tear; encroachment on the thecal sac and foramina bilaterally; compromise of the traversing and exiting nerve roots; facet joints satisfactory; 3 mm anterior disc protrusion. At L5-S1: Dehydration of the disc, 3-4 mm posterior disc bulge with encroachment on the epidural fat; encroachment on the foramina, with compromise of the exiting nerve roots bilaterally; no compromise of the traversing nerve roots; 1 mm anterior disc bulge. The report does not mention spondylolisthesis, instability, or facet arthropathy. The progress report dated 10/22/2014 indicates similar complaints of neck and back pain with tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot in the L5 and S1 dermatomal patterns. There was 4 out of 5 strength in the extensor hallucis longus and ankle plantar flexors. Ankle reflexes were asymmetric. The report does not specify which side was diminished. California MTUS guidelines indicate surgical considerations for severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise, activity limitation due to radiating leg pain for more than one month, 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 failure of conservative treatment to resolve disabling radicular symptoms. The guidelines for a spinal fusion indicate that 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. The MRI findings do not indicate any evidence of spondylolisthesis or instability at the requested levels. On page 310 the guidelines state that spinal fusion in the absence of fracture, dislocation, complications of tumor, or infection is not recommended. As such, the request for posterior lumbar interbody fusion is not supported by guidelines and the medical necessity of the request is not substantiated.

**Associate Surgical Service: Front wheel walker:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 306, 307, 310.

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

**Associate Surgical Service: Ice unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 306, 307, 310.

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

**Associate Surgical Service: Bone stimulator:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 305, 306, 307, 310.

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

**Associate Surgical Service: TLSO:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 305, 306, 307, 310.

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

**Associate Surgical Service: 3-1 Commode:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 305, 306, 307, 310.

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

**Associate Surgical Service: Inpatient stay two to three days:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 305, 306, 307, 310.

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

**Associate Surgical Service: Medical clearance with Internist:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 305, 306, 307, 310.

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

**Associate Surgical Service: Surgical assistant:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 305, 306, 307, 310.

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