

<b>Case Number:</b>	CM15-0101249		
<b>Date Assigned:</b>	06/04/2015	<b>Date of Injury:</b>	09/26/2013
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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: 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 30-year-old male who sustained an industrial injury on 9/26/13. Injury occurred when he was holding an extension ladder that collapsed and he tried to stabilize it, hyper-extending his back. Conservative treatment had included physical therapy, activity modification, home exercise program, and medications. The 2/9/15 lumbar spine MRI impression documented a central posterior disc protrusion at L4/5 with compromise of the traversing nerve roots and bilateral acquired foraminal stenosis with compromise of the exiting nerve roots bilaterally. At L5/S1, there was 3 mm posterior disc bulge with bilateral acquired foraminal stenosis and compression of the exiting nerve roots bilaterally. The 3/31/15 treating physician report cited severe back and bilateral leg pain. Prior lumbar epidural steroid injection provided 70% relief for 2 months, then the pain returned more severe. He had increased lower back pain into the legs. Pain was grade 8/10 without medications, and 4/10 with medications. Physical exam documented lumbar spasms, positive nerve tension signs, facet joint tenderness, decreased L4-S1 sensation and 4/5 right motor strength. The injured worker had bilateral L4-S1 radiculopathy. Authorization was requested for anterior spinal fusion/posterior spinal fusion at L4-S1 with unspecified length of stay. The 5/5/15 utilization review non-certified the requests for anterior and posterior spinal fusion and the associated length of stay as there was no documentation of instability to warrant fusion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior Spinal Fusion L4-L5:** 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 12 Low 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 indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. 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 injured worker presents with severe back and bilateral leg pain. Clinical exam findings are consistent with imaging evidence of nerve root compression at the L4/5 and L5/S1 levels. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no radiographic evidence of spinal segmental instability to support the medical necessity of surgery. Additionally, there is no evidence of a psychosocial screen. Therefore, this request is not medically necessary.

**Posterior Spinal Fusion L4-5:** 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 12 Low 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 indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. 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 injured worker presents with severe back and bilateral leg pain. Clinical exam findings are consistent with imaging evidence of nerve root compression at the L4/5 and L5/S1 levels. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no radiographic evidence of spinal segmental instability to support the medical necessity of surgery. Additionally, there is no evidence of a psychosocial screen. Therefore, this request is not medically necessary.