

<b>Case Number:</b>	CM15-0133979		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	10/05/2012
<b>Decision Date:</b>	08/21/2015	<b>UR Denial Date:</b>	07/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2015

### 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:

This injured worker is a 57-year-old female who sustained an industrial injury on 10/05/12. Injury occurred relative to lifting a patient with onset of low back pain. Past medical history was reported positive for morbid obesity (BMI 47) hypertension, hepatitis, and depression. Social history indicated she was a non-smoker. Conservative treatment had included medications, physical therapy, activity modification, and lumbar epidural steroid injection. The 9/17/14 lumbar spine MRI impression documented mild disc height loss at L3/4 with facet arthropathy and a 3-4 mm central disc protrusion causing mild spinal canal stenosis. At L4/5, there was mild disc height loss with facet arthropathy and a 1-2 mm diffuse disc bulge with normal spinal canal and mild right neuroforaminal stenosis. At L5/S1, there was facet arthropathy with a 1-2 mm central disc protrusion and normal spinal canal and neural foramina. The 10/6/15 addendum to the lumbar spine MRI stated that there was asymmetric severe right sided disc height loss at L4/5 with sclerotic endplate changes. The left L4/5 disc space was intact. There was mild asymmetric right neuroforaminal narrowing at L4/5. The 1/30/15 lumbar spine x-rays (2-3 views) documented a loss of disc height at L4/5. The 5/29/15 second opinion report cited low back pain with bilateral lower extremity radiculopathy. Physical exam documented lumbar facet pain bilaterally from L3-S1 and pain over the intervertebral disc spaces with palpation. There was loss of lumbar flexion with pain in all lumbar motions. Neurologic exam documented 4/5 psoas and quadriceps strength bilaterally. There was decreased bilateral hip sensation and 2+ and symmetrical deep tendon reflexes. Imaging showed L4/5 degenerative disc disease with facet arthropathy. Two prior lumbar epidural steroid injections provided minimal to no benefit.

Conservative treatment had failed. Authorization was requested for L4/5 posterior lumbar interbody fusion with instrumentation, assistant surgeon, and pre-operative evaluation with primary care provider. The 7/6/15 utilization review non-certified the request for L4/5 posterior lumbar interbody fusion with instrumentation and associates surgical requests as there was no documentation of a focal neurologic deficit or instability.

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

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

**L4-5 post lumbar interbody fusion with instrumentation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, 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 Lumbar & Thoracic, Discectomy/Laminectomy, 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. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines do not recommend lumbar fusion for patients with degenerative disc disease, disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or non-specific low back pain. Fusion may be support for segmental instability (objectively demonstrable) including excessive motion, as in isthmic or degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. Pre-operative clinical surgical indications include all of the following: (1) all physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts including skilled therapy visits, and performance of home exercise program during and after formal therapy. Physical medicine and manual therapy interventions should include cognitive behavioral advice (e.g. ordinary activities are not harmful to the back, patients should remain active, etc.); (2) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or MRI demonstrating nerve root impingement correlated with symptoms and exam findings; (3) Spine fusion to be performed at one or two levels; (4) Psychosocial screen with confounding issues addressed; the evaluating mental health professional should document the presence and/or absence of identified psychological barriers that are known to preclude post-operative recovery; (5) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing; (6) There should be documentation that the surgeon has discussed potential alternatives, benefits and risks of fusion with the patient. Guideline criteria have not been fully met. This injured worker presents with low back pain and bilateral lower extremity radiculopathy. Clinical exam findings are consistent with imaging evidence of degenerative disc disease at L4/5 with plausible nerve root compression. 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. There is no discussion of the need for wide decompression that would result in temporary intraoperative instability. Additionally, records suggest potential psychological issues with no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.

**Associated surgical service: 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.

**Preoperative evaluation with primary care provider:** 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.