

<b>Case Number:</b>	CM15-0134194		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	02/06/2013
<b>Decision Date:</b>	09/15/2015	<b>UR Denial Date:</b>	06/26/2015
<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: California

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 49 year old female, who sustained an industrial injury on 2/6/13. Initial complaints were not reviewed. The injured worker was diagnosed as having degeneration lumbar/lumbosacral intervertebral disc; thoracic or lumbosacral neuritis or radiculitis unspecified; chronic pain syndrome; insomnia unspecified; postlaminectomy syndrome lumbar region. Treatment to date has included physical therapy; epidural steroid injection right L4-5/L5- S1/epidurography (7/25/13); urine drug screening; medications. Diagnostics studies included CT myelogram lumbar spine (9/17/13); EMG/NCV study lower extremities (5/16/15). Currently, the PR-2 notes dated 6/5/15 indicated the injured worker complains of constant low back pain. She describes the pain as sharp, stabbing, more on the right side with radiation to the right buttock and occasionally to the whole right leg. The pain averages 5-7/10 in intensity. She reports occasional numbness in the right foot and notes she is limited functionally. She is able to stand 20 minutes and sit for 30 minutes and walk 15-20 minutes. She spends most of her day lying down with a heating pad and states she does not sleep well. She sleeps better with Ambien. She reports taking Percocet several times a week but tires to take as less medications as possible. She is a status post L5-S1 decompression and fusion and has had a transforaminal epidural steroid injection at right L4-5 and L5-S1 with epidurography in 2013. A CT myelogram dated 9/17/13 is documented as revealing multilevel degenerative changes, L5-S1 solid global fusion; moderate multifactorial acquired L4-5 moderate central canal stenosis with mild to moderate foramina narrowing, mild anterolisthesis with some instability; multilevel facet arthropathy. Objective findings from 4/10/15 are documented as range of motion in the low back is significantly limited to extension and right lateral bending. Rotation and oblique

extension is painful, more on the right side. There is tenderness to palpation along the right SI joint and along the low facet joints. Motor is 5/5/ throughout the lower extremities muscles except the right ankle dorsal flexion and great toe extension which are 4/5. She has decreased sensation to pinprick along the right L4-5 and S1 levels of the dermatomal distribution. Straight leg raising is negative bilaterally. The provider is requesting authorization of anterior and posterior L4-L5 fusion and decompression; back brace; cane, bone stimulation; and LOS (length of stay) duration unknown.

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

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

#### **Anterior and posterior L4-L5 fusion and decompression: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

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

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm, severe stenosis or psychiatric clearance from the exam note of 4/10/15 to warrant fusion. Therefore the determination is not medically necessary for lumbar fusion.

#### **Associated surgical service: Back Brace: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

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

**Associated surgical service: Bone stimulation: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Bone growth stimulator.

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

**Associated surgical service: Cane: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & leg.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Walking aids.

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

**Associated surgical service: LOS; duration unknown: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, low back, hospital length of stay.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Hospital length of stay.

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