

<b>Case Number:</b>	CM15-0160315		
<b>Date Assigned:</b>	08/26/2015	<b>Date of Injury:</b>	07/02/2014
<b>Decision Date:</b>	10/05/2015	<b>UR Denial Date:</b>	08/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/17/2015

### 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 59-year-old male who sustained an industrial injury on 7/2/14. Injury occurred when he picked up a 300-pound can. Past surgical history was positive for left total hip replacement in July 2011. Past medical history was positive for hepatitis, liver disease, pneumonia, and stomach ulcers. Social history indicated that he was a current some day smoker. Conservative treatment included activity modification, medications, epidural steroid injection, and physical therapy. The 7/25/14 lumbar spine MRI impression documented L5/S1 spondylolisthesis with bilateral L5 foraminal stenosis, severe, as a function of that deformity. The 8/6/15 treating physician report cited spine pain from the neck to the low back, with left lower extremity radicular pain right greater than left, and thoracic spine pain that was severe. Review of systems was positive for depression and drug dependence. Physical exam documented normal gait and station, symmetrical patellar and Achilles reflexes with no clonus, lumbar paraspinal tenderness to palpation, and right S1 and L5 hypesthesia. The injured worker was able to walk on their heels, walk on their toes, and squat. Lumbar range of motion was moderately diminished in extension. Flexion and extension views of the lumbar spine were obtained and documented an L5/S1 spondylolisthesis 11.4 in flexion and 11.5 extension. The diagnosis included low back pain secondary to L5 spondylolysis, L5/S1 isthmic spondylolisthesis, bilateral severe L5 foraminal stenosis, thoracic pain secondary to advanced spondylosis, and neck pain secondary to advanced degenerative disc disease from C6/7 and C7/T1. The injured worker had intolerable pain affecting his daily life and preventing him from working. He had exhausted physical therapy and other means of physical rehabilitation without significant improvement, and

lumbar injection without significant relief. The treatment plan recommended L5/S1 anterior lumbar interbody fusion (ALIF) with prosthesis, bone morphogenetic protein, and plating. Authorization was requested for an L5/S1 anterior lumbar interbody fusion (ALIF) with prosthesis with bone morphogenetic protein and plating, consult regarding anterior approach, 2-3 day in hospital stay, assistant surgeon, pre-operative comprehensive metabolic panel (CMP), complete blood count (CBC), prothrombin time (PT) and partial thromboplastin (PTT). The 8/14/15 utilization review non-certified the L5/S1 ALIF and associated surgical requests as there was no evidence of spinal instability and no indication for disc prosthesis.

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

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

**Consultation with Dr. regarding anterior approach:** 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.

**L5-S1 anterior lumbar fusion:** 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): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

**Decision rationale:** The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. 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 supported 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, with relative angular motion greater than 15 degrees L1-2 through L3-4, 20 degrees L4-5, 25 degrees L5-S1. Spinal instability criteria includes lumbar inter-segmental translational movement of more than 4.5 mm. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability and/or imaging demonstrating nerve root impingement correlated with symptoms and exam findings, spine fusion to be performed at 1 or 2 levels, psychosocial screening with confounding issues addressed, and smoking cessation for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been met. This injured worker presents with low back pain radiating into the lower extremities, right greater than left. Clinical exam findings were consistent with plausible nerve root compromise at the L5/S1 level. Evidence of long-term reasonable and/or comprehensive non-operative treatment and failure has been submitted. There is radiographic evidence of spondylolisthesis at the L5/S1 level with slight movement in flexion/extension which is not consistent with guideline criteria for instability. There is no discussion or imaging evidence supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. Potential psychological issues are documented with no evidence of a psychosocial screen. Additionally, the injured worker is noted to be a current some day smoker with no evidence of smoking cessation consistent with guidelines. Therefore, this request is not medically necessary at this time.

**Associated surgical services: 2-3 days in-patient stay: 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.

**Associated surgical services: 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.

**Associated surgical services: Pre-op labs: CMP: 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.

**Associated surgical services: Pre-op labs: CBC:** 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.

**Associated surgical services: Pre-op labs: PT, PTT:** 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.