

<b>Case Number:</b>	CM15-0166119		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	12/19/2012
<b>Decision Date:</b>	10/27/2015	<b>UR Denial Date:</b>	08/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/24/2015

### 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 51 year old female who sustained an industrial injury on 02-19-2012. The injured worker was diagnosed with multi-level lumbosacral degenerative disc disease and lumbago. According to the primary treating physician's progress report on July 27, 2015, the injured worker continues to experience worsening low back pain radiating to the lower extremities and currently using a walker for ambulation and support. Examination demonstrated lumbar range of motion limited to extension greater than flexion with pain in the low back and moderate limitation to rotation with back pain. There was tenderness to pressure over the midline and bilaterally and symmetrically at the paraspinal muscles at L4-5 and L5-S1. Positive muscle tightness was documented in the low lumbar region, left side greater than the right side. Straight leg raise was positive on the left with localized low back pain and left leg pain and positive on the right with localized low back pain and right leg pain. Motor strength with generalized deconditioning was documented in the lower extremities. Sensation was decreased over the left L5 and S1 dermatomes and mildly decreased over the right L5 and S1 dermatomes. On June 17, 2015, the surgical provider's examination noted satisfactory sensory, motor and deep tendon reflexes and the magnetic resonance imaging (MRI) (no date documented) showed abnormal discs at L4-5 and L5-S1. Prior treatments documented to date have included diagnostic testing, bilateral transforaminal epidural steroid injection (ESI) on December 10, 2014 achieving 60-70% reduction of lower back and bilateral leg pain for approximately 3 months, chiropractic therapy, acupuncture therapy, physical therapy, psychological sessions, walker for ambulation and medications. Current medications were listed as Hydrocodone, Cyclobenzaprine, Diclofenac, Gabapentin and Omeprazole. On July 7, 2015 the provider

requested authorization for inpatient staged arthrodesis: Stage 1-Fusion L4-S1 anterior removal discs L4-L5 and L5-S1 with allograft, Stage 2-posterolateral fusion L4-S1, insertion pedicle screws & rods, posterolateral bone grafting, assistant surgeon, 4 day hospital length of stay and pre-operative medical clearance. On 08-06-2015 the Utilization Review determined the request for inpatient staged arthrodesis anterior and posterior fusion of L4-S1 and associated services were not medically necessary due the absence of spinal instability.

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

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

**Inpatient Staged arthrodesis Stage 1 Fusion L4-S1 Anterior removal discs L4-L5 and L5-S1 with allograft, Stage 2 posterolateral fusion L4-S1, Insertion pedicle screws & rods, posterolateral bone grafting: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. 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 7/7/15 to warrant fusion. Therefore the determination is non-certification for lumbar fusion.

**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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical service: 4 day length of 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-operative medical clearance:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.