

<b>Case Number:</b>	CM15-0196644		
<b>Date Assigned:</b>	10/12/2015	<b>Date of Injury:</b>	08/04/2013
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	10/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2015

### 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: Minnesota, Florida  
 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 44 year old male, who sustained an industrial injury on 8-4-13. Per progress notes of September 28, 2015 the injured worker continues to have low back pain and neck pain with occasional left arm pain. A lumbosacral fusion had been recommended for his chronic degenerative disc disease at L5-S1. The MRI scan of the cervical spine revealed mild cervical spondylosis. No herniated disc and no significant spinal stenosis or neural foraminal encroachment at any level. The notes of this date do not include a comprehensive history or examination. Prior notes from May 1, 2015 in the form of a panel qualified medical examination neck and low back pain as well as right lower extremity pain related to an injury of 8/4/2013. The documentation indicates a pain level of 9/10-10/10 in the lumbar area. The pain was reported to be sharp and constant. There was some radiation into the right buttock and posterior thigh. The neck pain was reported to range from 4/10-9/10 and was associated with rare weakness in the right upper extremity. He also reported numbness and tingling in the palm of the left hand and in the left foot. Activities of daily living were "pretty minimal". The MRI of the lumbar spine dated 8/28/2013 was reported to show marked disc degeneration at L5-S1 , prominent Modic type I endplate change with trabecular edema, circumferential 2-4 millimeter disc bulge, greater than midline, bilateral facet arthropathy with foraminal narrowing, L4-5 mild disc degeneration with 1 mm circumferential left postero-lateral annular fissure without stenosis and no disc protrusion, central canal stenosis or fracture. EMG and nerve conduction studies were performed on 10/10/2013, which indicated "left motor and sensory nerve conduction study as well as IF wave unremarkable. Left knee myelogram was normal". Conclusion: There was no evidence of

left upper extremity, peripheral neuropathy or left cervical radiculopathy. Furthermore, there was no evidence of a lower extremity peripheral entrapment neuropathy or a lumbosacral radiculopathy. The provider recommended a reevaluation in 4 months if still symptomatic. On physical examination that day there was diffuse tenderness to palpation in the thoracolumbar spine with reflex spasm. Range of motion testing is 10° (a legible), side bend 10°, rotation 10°, forward flexion with fingertips coming to the proximal tibia. Supine sitting straight leg raise is negative. FABERE/Patrick sign is bilaterally negative. Thigh thrust elicits midline low back pain and not lateralized sacroiliac joint pain. There was only one of the non-organic signs of low back pain, that of truncal rotation. Neurologic examination revealed normal strength, normal deep tendon reflexes and decreased sensation to light touch and pinprick in the left lateral foot. X-rays of the lumbar spine including flexion/extension views dated 6/25/2014 were reported to show severe degenerative disc changes at L5-S1. There was stable alignment in neutral, flexion and extension maneuvers. MRI scan of the lumbar spine dated 6/25/2014 revealed advanced degenerative changes at L5-S1 with circumferential disc osteophyte complex and mild bilateral L5 neural foraminal encroachment. There was minor degenerative change with minimal disc bulging at L4-5 and suspected left paracentral annular tear. A request for lumbar interbody fusion at L5-S1 was noncertified by utilization review citing California MTUS guidelines.

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

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

#### **L5-S1 Anterior Lumbar Interbody Fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** California MTUS guidelines recommend surgical considerations for severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair and failure of conservative treatment to resolve disabling radicular symptoms. With regard to the request for a lumbar fusion, the guidelines indicate patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. However, there is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. In this case there is no objective neurologic deficit on examination. There is no electrophysiologic evidence of radiculopathy. Excessive pain levels are reported in the cervical

as well as lumbar area and the clinical examination, electrodiagnostic studies and imaging studies do not corroborate the same lesion that is known to benefit in both the short and long-term from surgical repair. There is no instability documented on the flexion/extension films and there is no spondylolisthesis present. The criteria for a fusion include spondylolisthesis with instability, which is defined as 4.5 mm of translation at L5-S1 on flexion/extension films. In the absence of such instability and absence of spinal stenosis warranting a wide decompression, and absence of fracture, dislocation, complications of tumor or infection, the request for spinal fusion at L5-S1 is not supported and the medical necessity of the request has not been substantiated.