

<b>Case Number:</b>	CM15-0035461		
<b>Date Assigned:</b>	03/03/2015	<b>Date of Injury:</b>	11/19/2002
<b>Decision Date:</b>	04/09/2015	<b>UR Denial Date:</b>	02/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2015

### 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: 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:

The injured worker is a 51-year-old male who sustained an industrial injury on 11/19/02. Injury occurred while pulling a baggage cart. He felt a pop in his low back with severe onset of low back and leg pain. Past medical history was positive for a stroke in 2010, seizure in 2012, hemochromatosis, gout, and sleep apnea. The 5/1/14 consult report cited low back pain radiating to the buttocks and posterior thighs to the knees. Pain was worse with standing or walking, better with rest or leaning forward. Conservative treatment had included physical therapy, medications (anti-inflammatories, narcotics and nerve agents), and pain management, including multiple radiofrequency ablations, medial branch blocks, and epidural steroid injections. There had been no meaningful benefit in terms of pain relief since 2013, although these interventions were very efficacious in the past. Physical exam documented normal gait, no lumbosacral tenderness, positive bilateral straight leg raise, and mild loss of lumbar flexion. Lower extremity motor strength and deep tendon reflexes were within normal limits. There was slightly decreased sensation over the dorsum and dorsolateral feet, right greater than left. Standing radiographs showed significant grade 1-2 spondylolisthesis at L4/5 and L5/S1. The treatment plan indicated that the patient had a recent MRI but it was not available for review. The patient was felt to be an appropriate candidate for a spinal fusion at L4/5 and L5/S1. The 5/1/14 lumbar x-rays documented moderately severe L4/5 and moderate L5/S1 spondylolisthesis. Flexion/extension films were not taken. The 12/11/14 treating physician cited frequent bilateral low back and right buttock pain. Pain was worse with physical activity, standing and walking. Pain as reduced with medications. The diagnosis was chronic lumbar back pain, lumbar degenerative disc and facet

disease, and anxiety/depression. He had a slight forward flexed posture and a steady broad based gait, and sat leaning forward in a chair. The treatment plan indicated that the patient was to complete a flex test and psychological evaluation. The 1/26/15 DWC form requested anterior/posterior fusion L4-S1, chest X-ray, inpatient day x 3 days, and pre op labs, including complete blood count (CBC), comprehensive metabolic panel (CMP), urinalysis (UA), partial thromboplastin time (PTT), and prothrombin time (PT). On 2/02/15, utilization review non-certified the request for anterior/posterior fusion L4-S1 and cited was MTUS AECOM Guidelines. The rationale for non-certification included no imaging evidence of instability and no active radiculopathy. The requests for chest X-ray, inpatient day x 3 days, and pre op labs, including complete blood count (CBC), comprehensive metabolic panel (CMP), urinalysis (UA), partial thromboplastin time (PTT), and prothrombin time (PT) were found not medically necessary as the surgical request was non-certified.

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

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

#### **Anterior/posterior fusion L4-S1: 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, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines state there is no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines state that spinal fusion is recommended an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, demonstrated spinal instability, spine pathology limited to 2 levels, and psychosocial screening. Guideline criteria have not been met. There is no current clinical exam evidence of nerve root compression. There is no current radiographic evidence of spinal segmental instability. There is documentation of anxiety and depression with no evidence of psychological clearance for surgery. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

#### **Inpatient x 3 days: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Hospital length of stay (LOS).

**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  $\frac{1}{2}$  Lumbar & Thoracic: Hospital length of stay (LOS).

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

**Pre op labs Complete blood count (CBC), Comprehensive metabolic panel (CMP), Urinalysis (UA), Partial thromboplastin time (PTT), Prothrombin time (PT):** Upheld

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

**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.

**Chest X-ray:** 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.