

Case Number:	CM15-0036858		
Date Assigned:	03/05/2015	Date of Injury:	08/08/2006
Decision Date:	04/16/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	02/26/2015

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 46 year old male, who sustained an industrial injury on 8/08/2006, when moving heavy boxes. The diagnoses have included degenerative spondylolisthesis. Treatment to date has included surgical (lumbar fusion XLIF L3-4, L4-5 and laminectomies and posterior spinal fusion at L3-4 on 4/29/2010) and conservative measures. Currently, the injured worker complains of back pain with radiation into the left leg and testicles. Pain was rated 2-3 with medication and 8-9 without. Objective findings included limited lumbar range of motion and an antalgic gait to the left, without the use of an assistive device. Computerized tomography of the lumbar spine, dated 12/13/2013, noted unchanged post-surgical changes from L3-L5, with no evidence of hardware failure, stable mild central canal stenosis at the L4-5 level, and stable disc protrusion at the L1-2 level, with flattening of the ventral aspect of the thecal sac. A computerized tomography of the lumbar spine, 7/09/2014, was referenced (Agreed Medical Examination 8/12/2014); however the right paraspinal region reveals solid bridging bone at L3-4, and at L4-5, there was no evidence of solid fusion. Current medications were not noted. Treatment plan included revision of lumbar fusion. On 2/12/2015, Utilization Review non-certified a request for lumbar spine fusion, noting the lack of compliance with Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Spine Fusion: 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) Treatment Index, 11th edition (web), 2013, low back chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307, 310. Decision based on Non-MTUS Citation ODG: Section: Low Back. Topic: Fusion.

Decision rationale: The primary treating physician's progress report dated December 30, 2013 indicates a history of low back injury on August 8, 2006 from moving heavy boxes. On April 20, 2010, the injured worker underwent lumbar fusion XLIF at L3-4, and L4-5 with anterior lumbar discectomy and interbody fusion with lateral retroperitoneal approach XLIF, placement of interbody fusion cages, laminectomy at L3-L4 and posterior spinal fusion at L3-4 with use of bone graft. The documentation indicates that he was taking tramadol on a monthly basis when seen in August 2012. Since that time, he had continued to experience episodic low back pain. Examination at that time did not reveal any neurologic deficit. Range of motion of the lumbar spine was moderately restricted. The provider is suspecting a possible pseudoarthrosis at L4-5 although there is no instability, radiolucency around the screws or documented evidence of motion at that level. The most recent CT scan of the lumbar spine has not been submitted; however, there is a report dated December 13, 2013. Per radiologist's interpretation this showed evidence of postsurgical changes at L3, L4, and L5 with stable screws traversing the vertebral bodies from the right side of the vertebral column with 1 screw noted at L3, 2 screws noted at L4, and 1 screw noted at L5. There was no evidence of any radiolucency to suggest loosening. Bilateral laminectomies were noted at L3-4. The central canal and foramina were patent. Mild bilateral facet hypertrophy and mild ligamentum flavum hypertrophy was noted at L4-5 with a bulge measuring 2-3 mm with mild central canal stenosis but the foramina were patent. At L5-S1 there was a broad-based bulge measuring 2-3 mm. The left neural foramen was slightly narrow. The right neural foramen was patent. The CT scan does not document the presence of pseudoarthrosis or loosening of the hardware. There is no instability identified. An agreed Medical Evaluation dated August 12, 2014 refers to a CT scan of the lumbar spine dated July 9, 2014 which showed anterior-posterior fusion of L3-L4 and L4-L5. There were areas of lucency; however, the right paraspinal region revealed solid bridging bone at L3-4. At L4-5, there was no evidence of solid fusion. The complete report is not submitted; however the diagnosis does not mention radiolucency around the hardware or the presence of a definite pseudoarthrosis. The current requests pertain to a lumbar fusion. The request is not clear with regard to the level that is being requested. There is no clear imaging evidence of a pseudoarthrosis and there is no evidence of motion, instability, or loosening of hardware noted. California MTUS guidelines indicate that patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. However, there is no good evidence about the long-term effectiveness of any form of decompression or fusion for degenerative spondylosis compared with natural history, placebo, or conservative treatment. In the absence of spinal fracture, dislocation, or spondylolisthesis a spinal fusion is not recommended. ODG guidelines indicate that revision surgery should be approached with extreme caution due to the less than 50% success rate reported in the medical literature. The

success rate for Worker's Compensation is much less. In light of the above, the request for a lumbar fusion (unspecified) is not supported and the medical necessity of the request has not been substantiated.