

Case Number:	CM15-0040502		
Date Assigned:	03/10/2015	Date of Injury:	05/21/2011
Decision Date:	05/05/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	03/03/2015

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 female who sustained an industrial injury on 5/21/11. Conservative treatment has included right L5 and S1 selective nerve root blocks on 6/25/13 and 7/23/13, and an L4/5 facet block on 12/3/14. The 6/12/14 lumbar CT scan impression documented multilevel mild facet degenerative changes, transitional vertebra at the lumbosacral junction, mild narrowing of the left neural foramen at L5/S1, and mild disc bulge at L4/5. The 8/11/14 lumbar MRI impression documented mild lumbar hyperlordosis, large presumptive hemangioma of L1, and no significant disc protrusion, central stenosis, or nerve root impingement in the lumbar spine. The 1/23/15 treating physician report indicated that facet blocks allowed a dramatic improvement over a short period. She was still experiencing on-going lower back pain with right lower extremity radiation. There were no neurologic deficits documented on the physical exam. Anterior L4/5 fusion was requested. The 2/4/15 medical legal report cited low back pain with weird sensations down her left leg and right foot numbness and burning. Pain was 3-8/10, and increased with bending, and prolonged walking, standing, or sitting. Physical exam documented positive straight leg raise bilaterally, slight extensor hallucis longus and anterior tibialis weakness on the right, absent patellar reflexes, and normal toe/heel walk. Lumbar x-rays showed a partial fusion at L5/S1, but otherwise normal alignment. The diagnosis included partial sacralization of the last lumbar segment and degenerative changes at L4/5. Recommended medical care included a 2-level anterior spine fusion at L4/5 and L5/S1. The 2/5/15 utilization review non-certified the request for lumbar fusion surgery as there was no evidence of progressive degenerative changes and loss of disc height on radiographic studies. The 2/17/15

treating physician report appeal letter stated the injured worker was severely disabled from her low back pain. She was taking significant medication to control her symptoms, and had exhausted conservative treatment. He indicated that the injured worker had a lumbosacral transitional vertebra that was slightly anteverted as evidenced by a high pelvic incidence and pelvic tilt. The L4/5 level was exposed to significant shear force which caused the degenerated disc, chronic annular tearing and facet atrophy seen on the CT scan and MRI. Although, she did not have classic listhesis or movement caused by spondylolisthesis, this type of force on a degenerated disc mechanically induces instability which could cause significant low back pain refractory to conservative treatment. He proposed an anterior interbody fusion with complete removal of the disc, placement of an FRA allograft with rhBMP centrally and locked in with an ATB plate.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar fusion; Anterior interbody fusion at L4-5 with FRA and ATB by Robert Pashman MD: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Fusion (spinal).

Decision rationale: The California MTUS guidelines indicate that lumbar spinal fusion may be considered for patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. Guidelines state there was 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 Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. This injured worker presents with severe function-limiting low back pain. There is clinical exam evidence of reflex change and motor deficit consistent with L4 and L5 nerve root compression. However, imaging documented no evidence of significant disc protrusion, central stenosis, or nerve root impingement in the lumbar spine. There is imaging evidence of a transitional vertebra which the treating physician report opined caused mechanically induced instability. There is evidence of recent conservative treatment with selective nerve root block, facet blocks, medication, and activity modification. However, detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial including physical

therapy or manual therapy interventions and failure has not been submitted. There is no evidence of a psychosocial screen. Therefore, this request is not medically necessary at this time.