

<b>Case Number:</b>	CM15-0046306		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	07/11/2013
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	03/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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 39-year-old female who sustained an industrial injury on 7/11/13. Injury occurred when he stepped on a step stool while lifting a box weighing approximately 95 pounds. The step stool slid, causing her to lose balance and twist, injuring her back. The 9/4/13 lumbar MRI impression documented L5/S1 disc desiccation with 2 mm retrolisthesis and 2-3 mm diffuse disc bulge with a central annular tear. There was no central or S1 lateral recess stenosis. There was minor anterior spondylosis, minute Schmorl's node, and Modic II signal alliteration. There was no significant foraminal stenosis. There was a 3 mm L4/5 annular disc bulge with right paramedian annular fissure, without central or significant foraminal stenosis. There was a 2 mm L3/4 annular disc bulge with a more focal right paracentral protrusion and annular tear, without significant central or foraminal stenosis. Records documented conservative treatment to include physical therapy, chiropractic, acupuncture, pain medications, epidural steroid injections, and activity modification without sustained improvement. A psychosocial consultation was provided on 2/10/15 and the patient was cleared to proceed with the fusion surgery. The 10/9/15 to 2/11/15 treating physician reports cited continued severe lower back pain radiating to the bilateral lower extremities. Physical exam documented forward bent posture, diffuse lumbosacral tenderness, flexion limited by low back pain, positive bilateral straight leg raise, and bilateral calf weakness. She was diagnosed with an L5/S1 disc herniation with bilateral sciatica. The treatment plan recommended anterior lumbar interbody fusion (ALIF) at L5/S1. The 3/2/15 utilization review non-certified the request for anterior lumbar interbody fusion

at L5/S1 and associated vascular surgeon consult as there was no radiographic or imaging documentation of instability.

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

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

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

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers' Compensation (ODG-TWC) Low Back Procedure Summary online version last updated 01/30/2015.

**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. Fusion may be supported for surgically induced segmental instability. 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 fully met. This patient presents with signs/symptoms and clinical exam findings consistent with imaging evidence of an L5/S1 disc herniation. There is evidence of psychosocial clearance for surgery. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no radiographic or imaging evidence of spinal instability. There is no documentation that suggests wide decompression is required and or that will inevitably result in intraoperative spinal instability. Therefore, this request is not medically necessary at this time.

#### **Consult with Vascular Surgeon: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental

Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.