

<b>Case Number:</b>	CM15-0051440		
<b>Date Assigned:</b>	03/24/2015	<b>Date of Injury:</b>	04/23/2012
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	02/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2015

### 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:

This injured worker is a 35-year-old male who sustained an industrial injury on 4/23/12. Injury occurred while he was removing a block wall. He tripped and fell, landing on his back. He sustained was unconscious for about 3 hours and hospitalized for 12 days for transient traumatic spinal cord shock. Past medical history was positive for hypertension, type II diabetes mellitus, and obesity. Treatment included in-patient physical therapy, anti-inflammatory medications, pain medications, activity modification, and epidural steroid injection. The 7/26/12 electrodiagnostic report documented findings of axonal polyneuropathy and bilateral meralgia paresthetica. The 8/5/13 lumbar spine MRI demonstrated a 3.5 mm L3/4 disc protrusion/extrusion causing canal stenosis and pressure on the thecal sac. There was a 3 mm disc protrusion at L4/5 indenting the thecal sac with no foraminal narrowing. There was L5/S1 spondylosis without spondylolisthesis or canal or foraminal stenosis. The 11/5/14 orthopedic report cited low back pain traveling to his legs and feet with episodes of numbness and tingling. Coughing and sneezing aggravated his lower back pain. Pain increased with bending, twisting, turning, and prolonged standing, walking, sitting, and driving. Pain medication and heating/ice packs provided temporary relief, and he used a lumbosacral support. Physical exam documented moderately antalgic gait, markedly increased hyperlordosis, lumbosacral tenderness, marked quadratus lumborum trigger points and spasms, marked loss of lumbar flexion, mild loss of other lumbar motions, and normal strength, sensation, and reflexes. Straight leg raise was reported at 30 degrees bilaterally. The diagnosis was grade 1 spondylolisthesis, closed head trauma, spinal cord trauma and transient quadriplegia, and lumbar spondylosis. The treatment plan recommended a core strengthening,

flexibility, and medically supervised weight loss program. The 2/16/15 orthopedic progress report cited complaints of lower back pain, status post three epidural injections. X-rays showed grade 1 spondylolisthesis. Physical exam documented antalgic gait, moderate to marked loss of lumbar range of motion, absent Achilles reflex bilaterally, and positive straight leg raise at 90 degrees bilaterally. Authorization was requested for neurosurgical consult and spinal fusion. The 2/26/15 utilization review non-certified the request for spinal fusion as there was no clinical evidence to support symptomatic spondylolisthesis or instability.

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

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

**Spinal Fusion:** 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 Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back  $\frac{1}{2}$  Lumbar & Thoracic, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines indicate that lumbar spinal fusion may be considered for patient with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. 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. Before referral for surgery, consideration of referral for psychological screening is recommended 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. The injured worker presents with a current complaint of lower back pain. There is limited clinical evidence to correlate with imaging evidence of nerve root compression, significant stenosis, or spinal instability. There is no radiographic evidence of spinal segmental instability. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. A psychosocial screen is not evidenced. Additionally, the level of reported spondylolisthesis or fusion is not specified. Therefore, this request is not medically necessary.

**Outpatient Neurosurgical consultation:** Overturned

**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 Page(s): 305.

**Decision rationale:** The California MTUS guidelines state that referral for surgical consultation is indicated for patients who have met specific criteria. Referral is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. There should be activity limitations due to radiating leg pain for more than 4 to 6 weeks. Guidelines require clear clinical, imaging, and electrophysiologic evidence of a lesion that has shown to benefit in the short and long term from surgical repair. Failure of time and an adequate trial of conservative treatment to resolve disabling radicular symptoms must be documented. Guideline criteria have been met. This injured worker presents with ungraded low back pain with no current documentation of lower extremity symptoms. There were absent Achilles reflexes however. Additional expertise regarding diagnosis and treatment would be reasonable. Therefore, this request is medically necessary at this time.