

<b>Case Number:</b>	CM15-0053057		
<b>Date Assigned:</b>	03/26/2015	<b>Date of Injury:</b>	07/31/2001
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2015

### 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 72-year-old male who sustained an industrial injury on 7/31/01, relative to a fall. Past medical history was positive for diabetes mellitus. The 11/14/14 lumbar spine MRI documented varying degrees of L2/3, L3/4, L4/5, and L5/S1 posterior disc protrusions. There was a very mild anterolisthesis L3 on L4. There was an L3/4 disc bulge that effaced the anterior thecal sac with moderate central stenosis, recess narrowing, and bilateral facet arthropathy and ligamentum flavum thickening. At L4/5, there was a disc protrusion that effaced the anterior thecal sac, narrowing the recesses and mild to moderate facet arthropathy with encroachment. There was an L5/S1 disc protrusion effacing the anterior thecal sac with marked narrowing of the recesses, moderate bilateral facet arthropathy with encroachment upon the neural recesses and neural foramen bilaterally. The 11/25/14 x-rays showed no evidence of instability in flexion/extension. The 12/29/14 CT scan of the pelvis documented extensive degenerative disc disease and facet arthritis, marked left hip joint arthritis, fusion right sacroiliac joint, and multiple fractures involving the transverse processes on the right L1-L3. The 11/25/14 treating physician report cited grade 8-9/10 lumbosacral pain radiating to the bilateral buttocks. Pain was worse with standing and walking, and better with sitting. There was marked increase in symptoms with walking 50 feet, and difficulty with balance. He used Naproxen and Norco with moderate relief. Physical exam documented symmetrical deep tendon reflexes, 4/5 left iliopsoas weakness, inability to tandem gait, tenderness left sacroiliac joint, and midline L5/S1 pain. The diagnosis included L3/4 stenosis with a grade I listhesis, L5/S1 collapsed disc with herniation and facet arthritic change, and left sacroiliac joint pain. The treatment plan recommended L3,

L4, L5, and S1 decompression fusion, 3-day hospital length of stay, and CT scan to assess for auto-fusion from lipping osteophytes at L3-L4-L5. The 3/10/15 utilization review non-certified the request for lumbar spine CT scan as a pelvic CT scan was performed 12/29/14 and included the lumbar spine allowing for visualization of the auto-fusion at L3-L4-L5. The request for L3, L4, L5, and S1 decompression fusion and associated inpatient stay was non-certified as there was evidence of an additional injury and no documentation of recent follow-up, neurogenic claudication, or the rationale for L5/S1 fusion.

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

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

**CT (computed tomography) scan of the Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 303-304.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back ½ Lumbar & Thoracic: CT (computed tomography).

**Decision rationale:** The California MTUS guidelines generally support CT scan over MRI for evaluation of bony structures. The Official Disability Guidelines generally support CT scan of the lumbar spine for evaluation of neurologic deficit following trauma, evaluation of pars defect if not identified on plain x-rays, and for post-operative evaluation of fusion. Guideline criteria have not been met. Records documented that a pelvic CT scan was provided on 12/29/14 and documented osseous evaluation of the lumbar spine. There is no compelling reason to support the medical necessity of additional imaging to assessment of the L3-L5/S1 region for auto-fusion. Therefore, this request is not medically necessary.

**(Lumbar) L3-L4-L5 and S1 (sacroiliac) Decompression Fusion:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back ½ Lumbar & Thoracic, Discectomy/Laminectomy, Fusion (spinal).

**Decision rationale:** The California MTUS guidelines recommend lumbar discectomy for carefully selected patients with nerve root compression due to lumbar disc prolapse. 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. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar laminotomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve

root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. 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 met. This patient presents with multilevel lumbar degenerative disc disease with signs/symptoms consistent with neurogenic claudication. There is imaging evidence of extensive degenerative disc disease, facet arthritis, and spinal stenosis from L3/4 to L5/S1 with stable anterolisthesis at L3/4. However, there is no 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. There is no evidence of a psychosocial evaluation. Therefore, this request is not medically necessary.

**Inpatient Stay (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, Low Back , Hospital, Length of Stay.

**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 i; 1/2 Lumbar & Thoracic: Hospital length of stay (LOS).

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