

<b>Case Number:</b>	CM14-0215983		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	07/01/2002
<b>Decision Date:</b>	03/03/2015	<b>UR Denial Date:</b>	12/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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 62-year-old male with a date of injury of 7/1/2002. The mechanism of injury was from lifting packages over a period of time. Per primary treating physicians report and request for authorization dated October 9, 2014, he continued to complain of severe low back pain and spasms that radiated into the right buttock, lateral thigh and calf associated with numbness and tingling. Gait was slow and guarded. Range of motion of the lumbar spine was markedly restricted in all directions and was painful. Motor function in the lower extremities was intact. There was decreased light touch sensation in the right lateral thigh and calf. A CT myelogram dated 8/13/2014 revealed “evidence of anterolisthesis of 7 mm at L4-5 with fusion of the vertebral bodies, interpedicular screws bilaterally, L4 and L5 are demonstrated in appropriate position. There is fusion of the facet joints. There is a decompressive laminectomy. There is adequate decompression of thecal sac without meningocele formation. Associated with anterolisthesis is minimal right subarticular and right L4 foraminal stenosis. There is moderate distal left foraminal stenosis due to spondylosis. The left foramen is patent. At the L3-4 disc space which is degenerated and narrowed with nitrogen gas seen centrally, there is evidence of a broad-based 4 mm bridging osteophyte. The central component along with hypertrophic change and ligamentum flavum facet joints contributes to bilateral subarticular and laterals recess stenosis and minimal to moderate central canal stenosis with flattening of the ventral and dorsal thecal sac. There is lateral spondylosis contributing to minimal bilateral right greater than left proximal foraminal stenosis. At the L2-3 disc space which is degenerated and narrowed there is evidence of a 2 mm retrolisthesis, a 3 mm diffuse bulge in the annulus along with lateral

spondylosis is present. There is minimal attenuation of the left L2 neural foramen due to spondylosis. At the L5-S1 disc space which degenerated and narrowed with nitrogen gas seen centrally, there is no central or S1 lateral recess stenosis. There is adequate opacification of thecal sac and left S1 root sleeve. There is lateral spondylosis with moderate proximal right and minimal to moderate left foraminal stenosis. There is no meningocele formation. There is a decompressive laminectomy. There are hypertrophic changes of unresected process.” The diagnosis was status post redo central laminectomy L4-5 and partial S1 with bilateral L4-L5 and L5-S1 laminotomy with use of microscope, removal of deep spinal implants, status post L4-5 spinal fusion with instrumentation, stenosis right at L5-S1 with conjoined nerve root, severe right L5-S1 and moderate left L5 sensory dysfunction consistent with a right S1 injury per neurodiagnostic studies in 12/08. Status post right resurfacing hip arthroplasty, lumbar spondylosis and advanced degenerative disc disease L1-L2, L2-L3, L3-L4, L4-L5, and L5-S1. Status post right medial meniscectomy for work related injury, probable right anterior cruciate ligament tear, foraminal stenosis L4-5 and L5-S1. The treatment recommendation was for a lumbar epidural injection at L3-4 on the right. A subsequent request for anterior lumbar interbody fusion via lateral retroperitoneal approach (XLIF) L1-2, L2-3, and L3-4, laminectomy L2-3 and L3-4 and L5-S1 revision, posterior lumbar interbody fusion L5-S1 and posterior spinal fusion with instrumentation L1-S1 with removal of spinal implants at L4 and L5 bilaterally with replacement of new instrumentation at those levels, unspecified length of hospital stay, was noncertified by utilization review citing MTUS and ODG guidelines. This is now appealed to an independent medical review.

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

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

**Lumbar Spine Fusion Combined:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307, 310.

**Decision rationale:** California MTUS guidelines indicate except for cases of trauma related spine fracture or dislocation, fusion of the spine is not usually considered during the first 3 months of symptoms. Patients with increased spinal instability after surgical decompression at the level of the degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that a spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as much better in the surgical group versus 14% much better in

the non-fusion group which is a 15% greater chance of being much better versus a 17% complication rate including 9% life-threatening or reoperation. The injured worker has had multiple prior surgical procedures on his spine with no long-term benefit. He has chronic low back pain. There is no documented evidence of instability at the levels requested. There is no new electrophysiologic evidence of radiculopathy necessitating decompression/fusion. The pain generator has not been identified. The request for a multiple level fusion through the anterior and posterior approach is not likely to result in any significant improvement of the chronic pain. The guidelines on page 310 indicate that spinal fusion is not recommended in the absence of fracture, dislocation, complications of tumor, or infection. As such, based upon California MTUS guidelines, the medical necessity of such a procedure is not substantiated.