

<b>Case Number:</b>	CM15-0015019		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	01/12/2008
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/26/2015

### 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 related injury on 1/12/08. Injury occurred due to repetitive lifting as a caregiver. She had complaints of cervical and lumbar spine pain. Past surgical history was positive for C5-6 and C6-7 anterior microscopic discectomy, partial corpectomy, anterior cervical interbody fusion with cage and allograft, and application of rigid segmental internal fixation on 12/10/09. The 4/14/08 lumbar spine MRI findings documented single level disc disease at L4/5 where there was a mild broad based disc bulge with tiny annular fissure that slightly indented the thecal sac, with mild neuroforaminal stenosis and bilateral facet arthropathy. The 6/16/10 treating physician report cited severe back pain radiating to her left lower extremity. She had gone to the emergency room last week due to pain. Physical exam documented lumbar paraspinal tenderness and spasms, moderate loss of range of motion, positive left straight leg raise, decreased left L4, L5 and S1 dermatomal sensation, normal deep tendon reflexes, and no lower extremity weakness or atrophy in a dermatomal pattern. Lumbar spine x-rays showed a slight L4/5 spondylolisthesis with significant motion on dynamic flexion/extension films. The patient had reportedly failed non-surgical treatment. She was diagnosed with L4/5 spondylolisthesis with discogenic pain. She required a decompression at L4/5 and would need a fusion given the degenerative spondylolisthesis that was present. The 8/26/10 lumbar spine 2-view x-rays documented grade 1 anterolisthesis of L5 over S1. The 9/28/10 pre-operative evaluation documented current medications to include Norco, Ambien, Oxycodone, and Klonopin. The patient underwent L4-5 posterolateral fusion with allograft and rigid segmental internal fixation, L4 and L5 bilateral microscopic partial laminectomy, lumbar

pedicle screw electric testing, and dual repair on 10/5/10. The treating physician requested retrospective authorization for the lumbar surgery. On 12/23/14 the request was non-certified. The utilization review physician cited the Medical Treatment Utilization Schedule guidelines and noted no formal imaging reports corroborating the diagnosis are present in the medical records. There was insufficient evidence in the record to document the presence of the reported L4-5 spondylolisthesis and support the medical necessity. Therefore the request was non-certified.

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

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

**Retro (DOS 10/05/2010): L4-5 posterior lumbar interbody fusion, decompression, posterolateral fusion with screws: 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 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 stated 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 patient presented with signs/symptoms and clinical exam findings consistent with imaging evidence of single level disc pathology at L4/5. There was no clinical exam evidence of motor deficit or reflex change. There was no imaging evidence of nerve root compression. The treating physician reported x-rays showed a slight spondylolisthesis at L4 on L5 with significant motion on flexion/extension films. The submitted AP/lateral x-ray report documented a grade I spondylolisthesis at L5 on S1. The provider reported failure of non-surgical treatment with no details of comprehensive conservative treatment available in the records reviewed. There was no evidence of a psychosocial evaluation, although anxiety medication was prescribed. Given that guideline criteria have not been met, this retrospective request cannot be determined to be medically necessary at this time.