MAXIMUS Federal Services

| Case Number: | CM15-0015110 | | |
|---|---|---|---|
| Date Assigned: | 02/03/2015 | Date of Injury: | 03/28/2001 |
| Decision Date: | 03/23/2015 | UR Denial Date: | 01/21/2015 |
| Priority: | Standard | Application Received: | 01/27/2015 |

## 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 79 year old male, who sustained an industrial injury on March 28, 2001. Past medical history was positive for diabetes and hypothyroidism. Past surgical history was positive for L5/S1 anterior/posterior fusion. Prior conservative treatment included multiple injections, physical therapy, acupuncture, and medications. The 11/11/14 treating physician report cited prior recommendations in 2011 to extend the lumbar fusion proximally from L3 to L5 on top of previous L5/S1 fusion, based on a 4/27/11 CT myelogram that demonstrated severe L3/4 stenosis and moderate L4/5 stenosis. CT findings evidenced mild retrolisthesis of L5 on L4 measuring 2.93 mm in flexion and 1.78 mm in extension. The patient had low back pain radiating to the left lateral thigh to the lateral foot with occasional numbness and tingling, and give-way weakness. He had moderate depression and anxiety. Surgical consult was recommended. The 12/12/14 initial consult report cited progressive back and left leg pain with difficulty in ambulation. Physical exam documented antalgic gait, positive left straight leg raise, 4/5 extensor hallucis longus and anterior tibialis weakness, diminished sensation dorsum left foot, and pain with lumbar extension. Lumbar x-rays demonstrated a solid instrumented anterior/posterior fusion at L5/S1 with spondylolisthesis at L4/5. The patient had failed conservative treatment including physical therapy, acupuncture, and injections. The treating physician requested approval for an L3-L5 posterior lumbar fusion with instrumentation, decompression, removal of hardware and spinal cord monitoring, preoperative labs, and one medical clearance. On January 21, 2015 Utilization Review denied the surgical request as there was no evidence of recent conservative treatment or significant muscle weakness or diminished

reflexes at the corresponding nerve root levels, citing the MTUS, ACOEM Guidelines, and ODG.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**L3-5, Posteroir fusion with instrumentation, decompression, removal of hardware, spinal cord monitoring:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Low Back ? 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 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 typically 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 signs/symptoms and clinical exam findings consistent with lumbar radiculopathy. There is 2011 imaging evidence of moderate to severe spinal stenosis at L3/4 and L4/5. There was evidence of mild degenerative spondylolisthesis at L4/5 but there is no documentation of guideline-associated instability based on guideline criteria. There is a report of moderate depression and anxiety with no evidence of a psychosocial evaluation. Detailed evidence of up to 6 month(s) of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

**Pre-Operative Labs:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Improvement (ICS) Preoperative Evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI);2006 Jul 33 p.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**One medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.