

<b>Case Number:</b>	CM15-0066444		
<b>Date Assigned:</b>	04/14/2015	<b>Date of Injury:</b>	01/04/2013
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	03/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2015

### 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 38-year-old male who sustained an industrial injury on 1/4/13. Injury occurred when he was working as a yard maintenance technician and lifted a compactor out of a truck. The 12/9/14 lumbar spine MRI demonstrated a 2-3 mm right paracentral and lateral recess broad-based disc protrusion extending into the right lateral recess and right neural foramen. The disc herniation was markedly diminished in size compared to prior exam and no longer displaces the right S1 nerve root. The foraminal component mildly narrowed the right neural foramen without nerve root impingement. The 2/2/15 lumbar spine x-rays documented mild multilevel intervertebral disc narrowing at L3/4, L4/5, and L5/S1. There was no documentation of flexion/extension films or instability. The 3/5/15 progress report cited back and bilateral lower extremity complaints. He was not able to tolerate prolonged standing, sitting, or lying down. Physical exam documented left sided limp, L3-S1 and paraspinal tenderness, and ability to heel/toe walk. There was 4+/5 bilateral extensor hallucis longus weakness, decreased sensation over the dorsomedial aspect of both feet, 2+ and symmetrical patellar reflexes, and 1+ and symmetrical Achilles reflexes. Straight leg raise was positive bilaterally. The diagnosis was chronic lumbosacral strain and moderate degenerative disc disease at L5/S1 with mild instability. The treatment plan indicated that the injured worker had failed conservative treatment and recommended L5/S1 fusion. Authorization was requested for posterior lumbar fusion L5/S1 using PEEK interbody cages, rod, bone morphogenetic protein, and screws, with inpatient length of stay 2-3 days and assistant surgeon. The 3/25/15 utilization review non-certified the request for posterior lumbar fusion L5/S1 using PEEK interbody cages, rod, bone morphogenetic protein

and screws, and the associated surgical services, as there was no radiographic evidence of spinal segmental instability. The 3/30/15 treating physician report appeal stated that the injured worker remained highly symptomatic with low back and bilateral lower extremity complaints despite comprehensive conservative treatment. The request for lumbar fusion was consistent with the second surgical opinion recommendations. There was mild instability at the L5/S1 level that meets the criteria for a lumbar fusion.

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

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

**Associated Surgical Service: Inpatient LOS (2-3 days): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 - Lumbar & Thoracic: Hospital length of stay (LOS).

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

**Posterior Lumbar Fusion L5-S1 (using PEEK interbody cages, rod, BMP and screws): 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): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic: Fusion (spinal).

**Decision rationale:** The California MTUS guidelines state 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. Guidelines state that spinal fusion is recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis. Spinal instability criteria includes lumbar inter-segmental movement of more than 4.5 mm. 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 persistent and function-limiting low back and bilateral lower extremity pain. Clinical exam findings are consistent with neural compression at the L5/S1 level. The most recent lumbar MRI demonstrated a disc herniation at L5/S1 extending into the right lateral recess and neural foramen with no current evidence for impingement of the right L5 nerve root. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no objective measured radiographic evidence documented in the provided records of spinal segmental instability consistent with guidelines. Additionally, there is no documentation of a psychosocial screen or psychological clearance for surgery. Therefore, this request is not medically necessary.

**Associated Surgical Service: Assistant Surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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.