

<b>Case Number:</b>	CM15-0092116		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	08/04/2002
<b>Decision Date:</b>	06/17/2015	<b>UR Denial Date:</b>	04/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2015

### 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 50-year-old female who sustained an industrial injury on 8/04/02. Injury occurred while she was carrying pots, tripped over an electrical cord and fell. She underwent L4/5 and L5/S1 decompression and fusion on 3/15/04. She underwent a right total knee replacement in 2014. The 2/25/15 lumbar spine CT scan impression documented posterior lumbar interbody fusion hardware from L4-S1 without evidence of complication. There was multifactorial mild spinal canal stenosis at L3/4 secondary to grade 1 retrolisthesis, a mild disc osteophyte complex and facet arthropathy with corresponding moderate bilateral neuroforaminal narrowing. Conservative treatment had included medication therapy, physical therapy, epidural steroid injection, and activity modification. The 2/26/15 treating physician note indicated that the injured worker had chronic low back pain, and was status post an L4-S1 fusion in the past. She had developed adjacent segment disease at L3/4 with retrolisthesis. There was neural compression at that level that was causing back and bilateral lower extremity pain. Recommendation was made to extend the fusion to the L3 level. The 4/15/15 treating physician note cited grade 8/10 pain. She was taking hydrocodone which made her pain bearable and allowed her to function. Physical exam documented a forward flexed posture, using a wheeled walker. She had no focal motor or sensory deficits in the lower extremity. Sitting straight leg raise increased her back pain. There was lumbar spine tenderness and spasms. Surgery had been recommended and she was awaiting approval. The 4/29/15 utilization review non-certified the request for extension of the lumbar fusion to the L3 level as there was no radiographic evidence of instability or clear evidence for radiculopathy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Extension of lumbar fusion to the L3 level:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**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. 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 chronic low back pain radiating to both lower extremities. Imaging findings documented a grade 1 spondylolisthesis with reported evidence of neural compression. However, there is no documentation suggestive of an acute or progressive neurologic deficit. Clinical exam findings do not evidence a focal neurologic deficit or positive nerve tension signs. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no radiographic evidence of spinal segmental instability. There is no documentation of a psychosocial screening or psychological clearance for surgery. Therefore, this request is not medically necessary.