

<b>Case Number:</b>	CM15-0092287		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	06/12/2013
<b>Decision Date:</b>	06/22/2015	<b>UR Denial Date:</b>	04/13/2015
<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:

This injured worker is a 33-year-old male who sustained an industrial injury on 6/12/13. Injury occurred when he was pushing a cart filled with approximately 100 pounds of parts. The cart fell over while he was holding it, and he felt an onset of left shoulder and low back pain. Records documented conservative treatment to include physical therapy, massage, chiropractic manipulation, TENS unit, interferential unit, oral medications, topical ointments, and activity modification. The 8/16/13 lumbar spine MRI impression documented a 3.4 mm grade 1 spondylolisthesis of L5 relative to S1 with disc desiccation, and mild loss of disc height. There was a 3.4 mm broad-based disc protrusion at L4/5 without central canal or neuroforaminal stenosis. Findings were suggestive of an early annular tear in the left paracentral aspect of the L5/S1 disc. The 1/27/14 lumbar spine CT scan impression documented bilateral spondylosis at L5 with grade 1 spondylolisthesis of L5 on S1 and central disc protrusion. The 1/8/15 lumbar spine weight bearing x-rays demonstrated mild hypolordosis with bilateral L5 pars fracture reactions with 20% narrowing of the L5/S1 disc space and mild sclerosis of the L5/S1 facets with grade 1 anterolisthesis at L5/S1. Flexion/extension views showed L5/S1 anterolisthesis of 0.84 cm in flexion versus 0.74 cm in extension. The 2/19/15 treating physician report cited on-going grade 7/10 low back pain and radicular right leg pain. He had increasing radicular leg pain radiating to the foot with numbness and weakness. Pain interfered with activities of daily living and he was unable to work. Medications included tramadol and gabapentin. X-rays of the lumbar spine with flexion/extension views revealed gross instability at L5/S1. Physical exam documented altered gait with a limp on the right leg, limited lumbar range of motion, right lower

lumbar spine and sciatic notch tenderness to palpation, and positive straight leg raise on the right. Neurologic exam documented 4/5 right dorsiflexion weakness, diminished right Achilles reflex, and decreased sensation over the right posterolateral thigh, calf and foot. The diagnosis was bilateral spondylosis with spondylolisthesis at L5/S1. The injured worker had significant abnormal findings on MRI consistent with his complaints and objective findings of radiculopathy on examination. He had gross instability of the spine due to spondylolisthesis with evidence of L5 and S1 nerve root compression. He had failed to respond to conservative treatment. Authorization was requested for anterior lumbar interbody fusion at L5/S1 with pedicle screw instrumentation and posterolateral fusion with bilateral facetectomy at L5/S1 for nerve root decompression and stabilization of the spine. The 4/13/15 utilization review non-certified the request for L5/S1 anterior lumbar interbody fusion and posterolateral fusion with bilateral facetectomy, 2-3 day inpatient length of stay and assistant surgery based on an absence of detailed evidence that the patient had failed an exhaustive course of conservative treatment. There were no neurologic deficits that would suggest urgent indications.

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

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

**Anterior Lumbar Interbody Fusion L5-S1 with Pedicle Screw Instrumentation, posterolateral fusion, bilateral facetectomy, allograft, autograft, mirco, fluoroscopy:**  
Overturned

**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 Procedure, Lumbar Fusion.

**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 i;½ Lumbar & Thoracic: Discectomy/Laminectomy, Fusion (spinal); Hospital length of stay (LOS); Surgical assistant.

**Decision rationale:** The California MTUS guidelines state there is 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. Before referral for surgery, consideration of referral for psychological screening is recommended to improve surgical outcomes. 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 been met. This patient presents with on-going function-limiting low back pain radiating into the right lower extremity with numbness and weakness. Signs/symptoms and clinical exam findings are consistent with imaging evidence of plausible L5 and S1 nerve root

compression. There is radiographic evidence of spinal segmental instability at L5/S1. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is no history of psychological issues documented in the submitted records. Therefore, this request is medically necessary.

**Associated surgical services: 2-3 days inpatient:** Overturned

**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); Hospital length of stay (LOS).

**Decision rationale:** The ODG recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for anterior or posterior lumbar fusion is 3 days. The requested treatment is medically necessary.

**Assistant Surgeon:** Overturned

**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); Surgical Assistant.

**Decision rationale:** Guidelines recommend an assistant surgeon for lumbar fusion. Since the surgery is medically necessary, the request for assistant surgeon is medically necessary.

**Pre-Operative Clearance:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM OMPG, Chapter 7, Independent Medical Examinations and Consultations, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have been met based on the magnitude of surgical procedure, recumbent

position, fluid exchange and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

**Associated surgical service: DME: Back Brace:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 12 Low Back Complaints Page(s): 9, 298 and 301.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines 2nd Edition, Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138 and 139.

**Decision rationale:** The California MTUS guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The revised ACOEM Low Back Disorder guidelines do not recommend the use of lumbar supports for prevention or treatment of lower back pain. However, guidelines state that lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. The use of a lumbar support in the post-operative period for pain control and stabilization is reasonable and supported by guidelines. Therefore, this request is medically necessary.