

<b>Case Number:</b>	CM14-0175848		
<b>Date Assigned:</b>	10/28/2014	<b>Date of Injury:</b>	03/08/2014
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Spine Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 53-year-old male with a 3/8/14 date of injury. At the time (9/11/14) of request for authorization for Anterior lumbar interbody discectomy and fusion of L4-S1, Assistant surgeon, Lumbosacral orthosis, and Post-op physical therapy 2 times 6, there is documentation of subjective (low back pain) and objective (tenderness over lumbosacral junction and limited left hip range of motion) findings, imaging findings (MRI lumbar spine (5/8/14) report revealed mild posterior disc bulge and facet arthropathy at L4-5 and L5-S1 with no spinal canal narrowing and mild bilateral neural foraminal narrowing at L5-S1), current diagnoses (mechanical low back pain and sciatica), and treatment to date (physical therapy and medications). Regarding Anterior lumbar interbody discectomy and fusion of L4-S1, there is no documentation of subjective (pain, numbness or tingling) and objective (sensory changes, motor changes, or reflex changes) findings which confirms presence of radiculopathy; imaging findings (nerve root compression or moderate or greater central canal, lateral recess, or neural foraminal stenosis) in concordance between radicular findings on radiologic evaluation and physical exam findings; and an indication for fusion (instability OR a statement that decompression will create surgically induced instability).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior lumbar interbody discectomy and fusion of L4-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**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 Discectomy/laminectomy and Fusion (spinal)

**Decision rationale:** MTUS reference to ACOEM identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Failure of conservative treatment; and an Indication for fusion (instability OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminotomy/fusion. ODG identifies documentation of Symptoms/Findings (pain, numbness or tingling in a nerve root distribution) which confirm presence of radiculopathy, objective findings (sensory changes, motor changes, or reflex changes (if reflex present)) that correlate with symptoms, and imaging findings (nerve root compression or MODERATE or greater central canal, lateral recess, or neural foraminal stenosis) in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression/laminotomy. Within the medical information available for review, there is documentation of diagnoses of mechanical low back pain and sciatica. In addition, there is documentation of failure of conservative treatment. However, despite nonspecific documentation of subjective (low back pain) and objective (tenderness over lumbosacral junction and limited left hip range of motion) findings, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness or tingling) and objective (sensory changes, motor changes, or reflex changes) findings which confirms presence of radiculopathy. In addition, despite documentation of imaging (MRI of lumbar spine identifying mild posterior disc bulge and facet arthropathy at L4-5 and L5-S1 with no spinal canal narrowing and MILD bilateral neural foraminal narrowing at L5-S1) findings, there is no documentation of imaging findings (nerve root compression or MODERATE or greater central canal, lateral recess, or neural foraminal stenosis) in concordance between radicular findings on radiologic evaluation and physical exam findings. Furthermore, there is no documentation of an Indication for fusion (instability OR a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for anterior lumbar interbody discectomy and fusion of L4-S1 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.

**Associated surgical service: Lumbosacral orthosis: 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.

**Associated surgical service: Post-op physical therapy 2 times 6: 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.