

<b>Case Number:</b>	CM14-0125804		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	10/10/2012
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	07/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/08/2014

### 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 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:

The injured worker is a 33-year-old male who reported an injury on 10/10/2012. The mechanism of injury was not submitted for clinical review. The diagnoses include lumbar sprain/strain, lumbago, multiple lumbar disc herniation, lumbar radiculitis/radiculopathy of lower extremity greater on the right side, lumbar paraspinal muscle spasms, sacroiliitis of the right sacroiliac joint, musculoligamentous strain of the lumbar spine, and impingement syndrome of the left shoulder. The previous treatments included medication, physical therapy, sacroiliac joint injections, and epidural steroid injections, surgery of the shoulder, and an L4-5 microdiscectomy and laminectomy. On 10/07/2014, it was reported the injured worker returned for a follow-up. The physical examination revealed the injured worker had tenderness to palpation over the paraspinal musculature. The range of motion was noted to be flexion at 60 degrees and extension at 25 degrees. The provider indicated the injured worker had diminished sensation over the right L5 dermatome. The injured worker was scheduled to undergo surgery. A request was submitted for an L4-5 anterior posterior decompression and fusion. However, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L4-L5 Anterior posterior decompression and fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Work Loss Data Institute, LLC; Corpus Christi, TX; Section: Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 07/03/2014)

**MAXIMUS 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, Decompression, Fusion

**Decision rationale:** The request for L4-5 anterior posterior decompression and fusion is not medically necessary. The California MTUS/ACOEM Guidelines state spinal fusion in the absence of fracture, dislocation, complications of tumor, or infection is not recommended. Spinal fusion is recommended with injured workers with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis who may be candidates for fusion. There is no scientific evidence about the long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. In addition, the Official Disability Guidelines state decompression may be a surgical procedure that is performed to alleviate pain caused by pinched nerves/neural impingement. For spinal fusion, criteria include the fusion should not be considered within the first 6 months of symptoms except for fracture, dislocation, or progressive neurological loss. Indications include neural arch defect, spondylolytic spondylolisthesis, and congenital neural arch hypoplasia. Segmental instability objectively demonstrated on the physical examination. Excessive motion as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, primary mechanical back pain such as pain aggravated by physical activity, functional spinal unit failure instability including 1 or 2 level segmental failure with progressive degenerative changes, loss of height, disc loading capability. The guidelines note there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in a rehab preop, disability over 6 months. The documentation submitted indicated the injured worker to continue to have tenderness to palpation. However, there is a lack of documentation indicating objective findings of segmental instability. There is a lack of documentation indicating the provider suspected the injured worker to have infection, tumor, or deformity of the lumbosacral spine that caused pain, neurological deficits, or functional disability. Additionally, there was a lack of a psychosocial screening provided for clinical review. Therefore, the request is not medically necessary.