

<b>Case Number:</b>	CM14-0171157		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	07/20/2011
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	09/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2014

### 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 Texas. 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 37-year-old female who reported an injury on 07/20/2011. The current diagnoses are moderate-to-severe facet spondylosis of the lumbar spine, discogenic syndrome, lumbar disc degenerative disease, lumbosacral radiculitis, and obesity. The clinical note dated 09/08/2014 revealed the injured workers complaints of constant, moderate to severe right hip and low back pain with radiation of pain into her right buttocks and right thigh. Additionally, she reports numbness and tingling in her right foot, which at times will cause her to fall. Upon examination, there was moderate tenderness to palpation over the spinous process and right paraspinal muscles. Range of motion of the lumbar spine is restricted. Current medication list included Norco, Topamax, Naproxen, and Neurontin. A lumbar discogram was positive at L5-S1. The provider recommended a lumbar spine fusion and post-operative physical therapy of the lumbar spine. The request for authorization form was not submitted in the documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior lumbar discectomy, partial corpectomy and fusion at L5-S1 with a cage/plate device plus iliac crest graft:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for Lumbar Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 305-307.

**Decision rationale:** The request for anterior lumbar discectomy, partial corpectomy and fusion at the L5-S1 with cage/plate device plus iliac crest graft is not medically necessary. The California MTUS/ACOEM Guidelines state that a spinal fusion is not recommended except in cases of trauma, spinal fracture or dislocation. Fusion of the spine is not usually considered for the first 3 months of symptoms. Injured workers with increased spinal instability after surgical decompression of the level of degenerative spondylolisthesis may be a candidate for fusion. There is no scientific evidence of long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylolisthesis compared with natural history, placebo or conservative treatment. There is no information on previous conservative therapy the injured worker underwent and the efficacy of those treatments. There is no objective signs of instability noted upon physical examination and no evidence of activity limitation or progressing lower leg symptoms or objective signs of neural compromise. There are no imaging studies that show evidence of neural compromise. As such, this request is not medically necessary.

**Lumbar laminectomy at L5 with foraminotomies over the L5 and S1 nerve roots as well as a bilateral lateral fusion at L5-S1 with pedicle screw hardware and right iliac crest graft:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for Lumbar Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 305-307.

**Decision rationale:** The request for lumbar laminectomy at L5 with foraminotomies over the L5 and S1 nerve roots as well as bilateral lateral fusion at the L5-S1 with pedicle screw hardware and right iliac crest graft is not medically necessary. The California MTUS/ACOEM Guidelines state that a spinal fusion is not recommended except in cases of trauma, spinal fracture or dislocation. Fusion of the spine is not usually considered for the first 3 months of symptoms. Injured workers with increased spinal instability after surgical decompression of the level of degenerative spondylolisthesis may be a candidate for fusion. There is no scientific evidence of long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylolisthesis compared with natural history, placebo or conservative treatment. There is no information on previous conservative therapy the injured worker underwent and the efficacy of those treatments. There is no objective signs of instability noted upon physical examination and no evidence of activity limitation or progressing lower leg symptoms or objective signs of neural compromise. There are no imaging studies that show evidence of neural compromise. As such, this request is not medically necessary.

**Post-operative physical therapy for the lumbar spine, twice weekly for six weeks:** 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.