Case Number:	CM14-0199386		
Date Assigned:	12/15/2014	**Date of Injury:**	12/23/2013
Decision Date:	01/26/2015	**UR Denial Date:**	11/17/2014
Priority:	Standard	**Application Received:**	11/26/2014

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 ENTER SUBSPECIALTY 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 59-year-old male who reported injuries due to heavy lifting on 12/23/2013. On 10/31/2014, his diagnoses included spondylolisthesis at L5-S1, herniation of intervertebral disc between L4 and L5, left L4-5 with radiculopathy, lumbar stenosis at L4-5 and L5-S1, lumbar spondylosis with myelopathy at L4-5 and L5-S1, spondylosis of lumbar region without myelopathy or radiculopathy at L3-4, sciatica of the left side, and anxiety disorder. His complaints included left buttock and hip pain with distal left lower extremity weakness. Electrodiagnostic studies performed on 09/30/2014, revealed no evidence of lumbar radiculopathy or polyneuropathy. They were deemed to be normal studies. An impression of a lumbar MRI on 01/06/2014 reportedly noted disc bulge at L4-5 and L5-S1 causing neural foraminal narrowing and left lateral disc protrusions at L4-5 also causing narrowing of left lateral neural recess. The original MRI was not available for review. He had received 2 epidural steroid injections, the first of which was of some help; the second was not as helpful. He had no complaints of bowel or bladder difficulties. On 10/09/2014, it was noted that he had seen excellent physicians and that his condition would probably worsen, and that the sooner surgery was performed, the sooner he would be able to heal and improve. There was no Request for Authorization included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 anterior fusion, L4-L5 artificial disc replacement, Posterior L5-S1 fixation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307; 310.

Decision rationale: The request for L5-S1 anterior fusion, L4-L5 artificial disc replacement, Posterior L5-S1 fixation is not medically necessary. The California ACOEM Guidelines note that within the first 3 months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative treatment and obviously due to a herniated disc is detected. Disc herniation may impinge on a nerve root, causing irritation, back and leg symptoms, and nerve root dysfunction. The presence of a herniated disc on an imaging study however, does not necessarily imply nerve root dysfunction. Some studies show that pain may be due to irritation of the dorsal root ganglion by inflammogens released from a damaged disc in the absence of anatomical evidence of direct contact between neural elements and disc material. Therefore, referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferable with accompanying objective signs of neural compromise, activity limitation due to radiating leg pain for more than 1 month, or extreme progression of lower leg symptoms, clear clinical imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standardized tests such as the MMPI 2. With or without surgery, more than 80% of patients with apparent surgical indications eventually recover. Although surgery appears to speed short to midterm recovery, surgical morbidity and complications must be considered. Surgery benefits fewer than 40% of patients with questionable physiologic findings. Moreover, surgery increases the need for future surgical procedures with higher complication rates. Except for cases of trauma related spinal fracture or dislocation, fusion of the spine is not usually considered during the first 3 months of symptoms. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis 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. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study has shown that only 29% assess themselves as much better in the surgical group versus 14% as much better in the nonfusion group, (a 15% greater chance of being much better) versus a 17% complication rate including 9% life threatening or reoperation. To support a surgical request, the appropriate diagnostic study has to be an original report. With no clear clinical imaging evidence or electrophysiologic concurrence of a lesion or radiculopathy, the guidelines do not support this procedure. Therefore, this request for L5-S1 anterior fusion, L4-L5 artificial disc replacement, Posterior L5-S1 fixation is not medically necessary.

6 days inpatient stay: 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.

Preoperative history and physical: 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.

Vascular 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.

Orthopaedic 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.