

<b>Case Number:</b>	CM14-0085353		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	12/16/2013
<b>Decision Date:</b>	01/02/2015	<b>UR Denial Date:</b>	05/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 60-year-old male who reported an injury on 12/16/2013. The mechanism of injury involved repetitive heavy lifting. The current diagnosis is lumbar spondylolisthesis. The injured worker presented on 05/13/2014 with complaints of persistent lower back pain. Previous conservative treatment is noted to include medication management, home exercise, physical therapy, and epidural steroid injection. The injured worker was utilizing Norco for pain on an as needed basis. Physical examination revealed an abnormal and antalgic gait, limited lumbar spine range of motion, forward flexion of 60 degrees, 30 degree extension, 25 degree lateral rotation, positive straight leg raise on the left at 60 degrees in the sitting position, and diminished sensation in the left L5-S1 distribution. Treatment recommendations at that time included an anterior lumbar fusion at L4-5 with posterior decompression and a facet cyst excision. It is noted that the injured worker underwent lumbar spine x-rays on 12/16/2013, which revealed degenerative L4 spondylolisthesis with moderate multilevel degenerative disc narrowing. The injured worker also underwent an MRI of the lumbar spine on 02/06/2014, which revealed grade 1 degenerative anterolisthesis with severe bilateral facet joint arthrosis and small left facet joint synovial cyst impinging the posterior thecal sac at L4-5. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior lumbar interbody fusion L4-5 and posterior decompression fusion L4-5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Discectomy/laminectomy, Indications for Surgery-Discectomy/laminectomy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Fusion spinal

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, clear clinical, imaging, and electrophysiologic evidence of a lesion, and failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. According to the documentation provided, the injured worker does have imaging evidence of anterolisthesis/spondylolisthesis at L4-5. The injured worker has also exhausted conservative treatment. Despite conservative management, the injured worker continues to report persistent lower back pain with radiation into the lower extremities. However, there is a lack of documentation of a psychosocial screening completed prior to the request for a lumbar fusion. Therefore, the injured worker does not meet the criteria as outlined by the above mentioned guidelines. As such, the request cannot be determined as medically appropriate at this time.

**Consult with [REDACTED] for approach (Surgery): 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.

**Bone Stimulator: 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.

**Neuro-monitoring: 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.