

<b>Case Number:</b>	CM15-0106977		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	11/05/2012
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York  
 Certification(s)/Specialty: Neurological Surgery

### 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 (IW) is a 52-year-old female who sustained an industrial injury on 11/05/2012. Diagnoses include degenerative thoracic/lumbar intervertebral disc and spondylolisthesis. Treatment to date has included medications, physical therapy, epidural steroid injections and activity modification. CT of the lumbar spine on 1/3/13 demonstrated bilateral L5 spondylolysis with grade I anterolisthesis at L5-S1 and degenerative retrolisthesis at L4-5. According to the PR2 dated 8/19/14 the IW reported lower back pain radiating down the bilateral legs, right greater than left, causing pain and tingling. She stated the majority of her pain was in the lower back. The pain interfered with sleep. On examination, the lower lumbosacral region was tender to palpation, flexion was 40 degrees and extension was 20 degrees. Straight leg raise testing was positive bilaterally for lower back and leg pain. Bilateral gastrocnemius reflexes were 1+/4. Due to continued complaints after two years of conservative treatment, a request was made for one posterior lumbar decompression laminectomy at L4-L5 and L5-S1 with reduction of spondylolisthesis, fixation and fusion, additional level, inset spine fixation device, additional level, autograft, remove vertebral body, additional level; anterior lumbar discectomy and interbody fusion at L4-L5 and L5-S1 with iliac crest autograft, apply spine prosthesis device, insert spine fixation device, autograft, arthrodesis; co-surgeon; hospital stay 3 days for posterior surgery and 3 days for anterior surgery QTY: 6; pre-operative electrocardiogram and labs: CBC, PT, PTT, UA, BMP; pre-operative chest x-ray; post-operative lumbar brace; postoperative cold therapy unit; and post-operative DVT Max unit.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Posterior Lumbar Decompression Laminectomy @ L4-L5, L5-S1 with reduction of Spondylolisthesis, Fixation and Fusion, additional level, inset spine fixation device additional level, autograft, remove vertebral body, additional level:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-310.

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

**Decision rationale:** The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. Documentation does not provide evidence of pathologic movement of lumbar spine. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Posterior Lumbar Decompression Laminectomy @ L4-L5, L5-S1 with reduction of Spondylolisthesis, Fixation and Fusion, additional level, inset spine fixation device additional level, autograft, remove vertebral body, additional level is not medically necessary and appropriate.

**Anterior Lumbar Discectomy and Interbody Fusion @ L4-L5, L5-S1 with iliac crest autograft, apply spine prosthesis device, insert spine fixation device, autograft, arthrodesis:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-310.

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

**Decision rationale:** The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. Documentation does not provide evidence of pathologic movement of the lumbar spine. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Anterior Lumbar Discectomy and Interbody Fusion @ L4-L5, L5-S1 with iliac crest autograft, apply spine prosthesis device, insert spine fixation device, autograft, arthrodesis is not medically necessary and appropriate.

**Associated surgical services: Co-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.

**Hospital Stay 3 days for posterior surgery & 3 days for anterior surgery QTY: 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.

**Preoperative Electrocardiogram and Labs: CBC, PT, PTT, UA, BMP:** 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 Chest X-ray:** 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.

**Postoperative Lumbar Brace:** 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.

**Postoperative Cold Therapy Unit:** 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.

**Postoperative DVT Max Unit:** 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.