

<b>Case Number:</b>	CM15-0016511		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	08/31/2011
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	01/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2015

### 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: Minnesota, Florida  
 Certification(s)/Specialty: Orthopedic 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 is a 47 year old female, who sustained an industrial injury on 08/31/2011. She has reported subsequent low back and right lower extremity pain and was diagnosed with root injury of the right lumbar spine from prior surgery. Treatment to date has included oral pain medication, orthosis, trigger point injections and a nerve root block. In a progress note dated 12/22/2014, the injured worker complained of low back, right knee and right foot pain that was rated as 7/10. Objective physical examination findings were notable for mild lumbar spasms in the lower lumbar spine, diminished range of motion in flexion and extension with pain, pain with lateral flexion and positive straight leg raise. The physician noted that the injured worker had failed conservative treatment for severe low back and right leg pain and requested authorization of anterior lumbar interbody fusion, posterior spinal fusion of L4-S1 and associated surgical services. On 01/08/2015, Utilization Review non-certified requests for anterior lumbar interbody fusion L4-S1 with removal of right disc fragment L5-S1 from anterior approach, posterior spinal fusion L4-S1, co-surgeon, 2 day inpatient hospital stay and pre-operative MRI noting that the documentation failed to demonstrate notable neurologic deficits in the lower extremities and that since the primary surgical procedure was not medically necessary, the associated surgical services were not medically necessary. MTUS and ACOEM guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) surgery - ALIF L4-S1 with removal of RT disc fragment L5-S1 from anterior approach; PSF L4-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-306.

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

**Decision rationale:** Per electromyography report of September 27, 2013, the injured worker developed a right foot drop subsequent to the low back surgery. Documentation indicates that there was no improvement in the foot drop. Electrodiagnostic studies revealed that the peroneal nerves were fine and the foot drop was due to a motor L5 radiculopathy. The operative report of March 9, 2012 indicates that she had undergone decompression at L4, L5, and S1 on the right. The postoperative diagnosis was disc herniation at L4-5 and L5-S1 with lateral recess stenosis. A progress note dated May 19, 2014 indicates persisting low back and right leg pain with associated numbness tingling and weakness. She still had the same right foot drop for which she was wearing an ankle-foot orthosis. She reported no new symptoms or changes. An MRI scan of the lumbar spine dated 9/19/2013 noted (1) An increase in the size of a protrusion at L4-5 level with an annular tear but still small in appearance and mildly indenting the thecal sac without abutting or compressing the nerve root. (2). There was a shallow excentric rightward mixed osteophyte/disc complex protrusion at L4-5 level which may abut the descending right S1 nerve root. Foraminal compromise, mild right sided at the L5-S1 level. In reading the body of the report, the radiologist is referring to the L5-S1 level and not the L4-5 level in the second conclusion. The documentation provided does not indicate any instability at L4-5 or L5-S1. There is no spondylolisthesis documented. California MTUS guidelines indicate patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no instability documented and there was no evidence of degenerative spondylolisthesis documented. The guidelines also indicate that 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. Lumbar fusion in patients with other types of low back pain very seldom cures the patient. On page 310 the guidelines state that spinal fusion in the absence of fracture, dislocation, complications of tumor, or infection is not recommended. As such, the request for anterior lumbar interbody fusion at L4-S1 and posterior lumbar spinal fusion at L4-S1 is not supported by guidelines and the medical necessity of the request is not substantiated.

**Associated surgical services: co-surgeon: 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), Low Back Chapter, Surgical Assistant.

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

**Decision rationale:** The requested surgery is not medically necessary. Therefore the request for ancillary services is also not medically necessary.

**Associated surgical services: 2-day inpatient hospital stay:** 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), Low Back Chapter, Hospital Length of Stay (LOS).

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

**Decision rationale:** The requested surgery is not medically necessary. Therefore the request for ancillary services is also not medically necessary.

**Pre-operative MRI:** 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) Low Back Chapter; MRIs (magnetic resonance imaging).

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

**Decision rationale:** The requested surgery is not medically necessary. Therefore the request for the preoperative MRI scan is also not medically necessary. Documentation indicates no change in the symptoms or neurologic deficit since the previous MRI and without surgery a repeat MRI is not indicated.