

<b>Case Number:</b>	CM15-0194632		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	07/13/2013
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	09/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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: New York, Montana, California  
 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 is a 57 year old female, who sustained an industrial injury on 7-13-2013. The injured worker is undergoing treatment for: lumbar spondylosis, left lumbar radiculopathy, lumbar disc herniation, lumbar spinal stenosis, and low back pain. On 9-10-15, she reported continued low back and bilateral lower extremity pain. On 9-25-15, a letter of appeal for the requested surgery that indicated a QME report was reviewed by the physician and it was concurrent with decision to recommend surgery. The letter indicated that a referral for psychological screening for clearance is agreed upon and would be beneficial. Physical examination revealed good strength noted bilaterally with toe and heel walk, able to squat with reported pain to her back, pain with lumbar spine range of motion, and standing slightly shifted to the left. The provider noted she did not have a diagnostic response to bilateral L3, L4, L5 medial branch block injections. The treatment and diagnostic testing to date has included: multiple physical therapy sessions reported as giving no significant relief, medications, medial branch blocks reported as not providing significant relief and indicated that she felt worse with them, magnetic resonance imaging of the lumbar spine (8-29-13) reported to revealed lumbar spurring, bulging discs, disc desiccation and some degenerative changes. Medications have included: Lyrica, gabapentin (noted as not providing significant relief), Current work status: not documented. The request for authorization is for: anterior interbody fusion through a lateral approach L2-5, post fusion L2-5 with instrumentation, 3 day inpatient stay, pre-operative examination, EKG, labs: urinalysis, CBC and chem 8. The UR dated 9-25-2015: non-certified the request for anterior interbody fusion through a lateral approach L2-5, post fusion L2-5 with

instrumentation, 3 day inpatient stay, pre-operative examination, EKG, labs: urinalysis, CBC and chem 8.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Anterior interbody fusion through a lateral approach L2-5/Post fusion L2-3 with instrumentation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Fusion (spinal).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of these conditions. The California MTUS guidelines do recommend lumbar surgery if there is clear clinical, electrophysiological and imaging evidence of specific nerve root or spinal cord level of impingement which would correlate with severe, persistent debilitating lower extremity pain unresponsive to conservative management. Documentation does not provide this evidence. Her magnetic resonance imaging scan (MRI) showed no severe canal or severe foraminal stenosis or nerve root impingement. Her provider recommended an anterior interbody lumbar arthrodesis through a lateral approach to treat her spondylosis without myelopathy and lumbago. Documentation does not present evidence of instability or radiculopathy. According to the Guidelines for the performance of fusion procedures for degenerative diseases of the lumbar spine, published by the joint section of the American Association of Neurological surgeons and Congress of Neurological surgeons in 2005 there was no convincing medical evidence to support the routine use of lumbar fusion at the time of primary lumbar disc excision. This recommendation was not changed in the update of 2014. The update did note that fusion might be an option if there is evidence of spinal instability, chronic low back pain and severe degenerative changes. Documentation does not show instability or severe degenerative changes. The California MTUS guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Anterior interbody fusion through a lateral approach L2-5/Post fusion L2-3 with instrumentation is not medically necessary and appropriate.

**Associated surgical service: 3 day inpatient 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:** 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.

**Associated surgical service: Electrocardiogram (EKG):** 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.

**Associated surgical service: Urinalysis (UA):** 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.

**Associated surgical service: Complete blood count (CBC):** 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.

**Associated surgical service: Chem 8:** 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.

**Pre op exam:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical systems improvement (ICSI). Preoperative evaluation. Bloomington (MN): 2010 June, 40 p.

**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.