

<b>Case Number:</b>	CM15-0198035		
<b>Date Assigned:</b>	10/13/2015	<b>Date of Injury:</b>	03/05/2011
<b>Decision Date:</b>	12/01/2015	<b>UR Denial Date:</b>	09/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2015

### 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 50 year old male, who sustained an industrial injury on 3-5-11. Medical records indicate that the injured worker is undergoing treatment for lumbar disc displacement without myelopathy, lumbar disc degeneration, psychogenic pain and chronic pain. The injured worker was noted to be permanent and stationary with permanent disability. On (9-26-15) the injured worker complained of low back pain and sciatica rated 8 out of 10 on the visual analogue scale. Examination of the lumbar spine revealed spasm with guarding and a positive straight leg raise test on the right. Treatment and evaluation to date has included medications, MRI of the lumbar spine, epidural steroid injections, physical therapy (unspecified amount), chiropractic treatments, psychotherapy sessions and acupuncture treatments. The MRI of the lumbar spine (7-30-15) revealed lumbar five-sacral one moderate disc degeneration with broad central four millimeter disc protrusion moderately narrowing both lateral recess and contacting the right sacral one nerve root. Current medications include Gabapentin, Cyclobenzaprine and Flonase. A physical therapy initial plan of care was noted in the medical records. No other physical therapy notes were provided. The request for authorization dated 9-9-15 included requests for a lumbar five-sacral one anterior spinal fusion and physical therapy for the lumbar spine 12 sessions. The Utilization Review documentation dated 9-30-15 non-certified the requests for a lumbar five-sacral one anterior spinal fusion and physical therapy for the lumbar spine 12 sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 anterior spinal fusion:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

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

**Decision rationale:** 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 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. Table 12-8 indicates that a spinal fusion is not recommended in the absence of fracture, dislocation, complication of tumor or infection. In this case there is no spondylolisthesis present. There is no instability documented. The MRI scan showed contact with the right S1 nerve root but no displacement of the nerve root was noted. The Achilles reflex is intact and there was no sensory loss in the S1 nerve root distribution documented. The decreased sensation was on the medial aspect of the foot. As such, the clinical findings do not corroborate the MRI findings and there is no electrodiagnostic study done. In any case, there is no documentation of instability and so the requested L5-S1 anterior interbody fusion is not supported and the medical necessity of the request has not been substantiated.

**Associated surgical service: 12 sessions of physical therapy, lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

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

**Decision rationale:** Since the primary surgical procedure is not medically necessary, none of the associated surgical requests are applicable.