Case Number:	CM15-0029981		
Date Assigned:	02/23/2015	**Date of Injury:**	12/09/2013
Decision Date:	04/09/2015	**UR Denial Date:**	02/10/2015
Priority:	Standard	**Application Received:**	02/18/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 59 year old female, who sustained an industrial injury on 12/9/13. She has reported lower back and right knee. The diagnoses have included right knee sprain, L5-S1 disc herniation and lumbosacral sprain. Treatment to date has included lumbar MRI, extracorporeal shockwave treatment, lumbar epidural and oral medications. As of the PR2 dated 1/30/15, the injured worker reports increased lower back pain with radiation to the bilateral lower extremities. She indicated that she is having difficulty walking and has occasional numbness in the right leg. The treating physician requested an anterior lumbar diskectomy and fusion at L5-S1 and a posterior fusion. On 2/10/15 Utilization Review non-certified a request for an anterior lumbar diskectomy and fusion at L5-S1 and a posterior fusion. The utilization review physician cited the MTUS and ACOEM guidelines. On 2/13/15, the injured worker submitted an application for IMR for review of an anterior lumbar diskectomy and fusion at L5-S1 and a posterior fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Anterior Lumbar Diskectomy and Fusion At The Levels Of L5-S1 And Posterior Fusion:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307-310.

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

Decision rationale: The patient presents with lower back pain with radiation to bilateral lower extremities and right knee pain. The request is for ANTERIOR LUMBAR DISCECTOMY AND FUSION AT LEVELS OF L5-S1 AND POSTERIOR FUSIONS. Physical examination on 01/30/15 to the lumbar spine revealed the L1 to S1 was normal. There was decreased sensation in the right lower extremity. MRI of the lumbar spine, date unspecified, revealed a moderate disc herniation at L5-S1. Patient's treatments have included physical and manipulation therapy, acupuncture, injections, ECSWT and medications. Per 12/19/14 progress report, patient's diagnosis include right knee sprain, MCL sprain in the right knee, discoid lateral meniscus right knee, lumbosacral sprain with radicular symptoms, L5-S1 moderate disc herniation, complains of right hand and numbness. Patient's medications per 01/30/15 progress report include Ultracet and Relafen. Patient's work status is modified duties. ACOEM ch 12, pg 305-6 Within the first three months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy (and obviously due to a herniated disk) is detected. Disk herniation, characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis, may impinge on a nerve root, causing irritation, back and leg symptoms, and nerve root dysfunction. The presence of a herniated disk on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disk herniations that apparently do not cause symptoms. Some studies show spontaneous disk resorption without surgery, while others suggest that pain may be due to irritation of the dorsal root ganglion by inflammogens (metalloproteinases, nitric oxide, interleukin- 6, prostaglandin E2) released from a damaged disk in the absence of anatomical evidence of direct contact between neural elements and disk material. Therefore, referral for surgical consultation is indicated for patients who have: "Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms." Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. "Failure of conservative treatment to resolve disabling radicular symptoms. ACOEM p 307 E. Spinal Fusion Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) 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. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as "much better" in the

surgical group versus 14% "much better" in the nonfusion group (a 15% greater chance of being "much better") versus 17% complication rate (including 9% life-threatening or reoperation). In this case, the patient complains of low back pain radiating into bil ateral lower extremities and right knee pain. The patient has failed conservative care including an ESI. Given the disc herniation, discectomy/laminectomy may be reasonable but the patient does not present with instability, fracture or dislocation to warrant a fusion surgery. The requested fusion surgery is not supported by the ACOEM. The request IS NOT medically necessary.