

<b>Case Number:</b>	CM14-0147731		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	07/05/2012
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	09/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2014

### 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. The expert reviewer is Board Certified in Orthopedic Spine Surgeon, and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 53-year-old male who reported an injury on 07/05/2012 after a fall of approximately 10 feet. The injured worker reportedly sustained an injury to multiple body parts to include the thoracic and lumbar spine. The injured worker's treatment history included physical therapy, epidural steroid injections, and medications. The injured worker underwent a CT scan of the lumbar spine on 07/29/2014 that documented there was a grade 1 spondylolisthesis at the L5-S1 with bilateral nerve root canal narrowing. The injured worker was evaluated on 08/12/2014. The injured worker's medications included oxycodone. Physical findings included significant lumbar tenderness causing restricted range of motion. The injured worker's treatment plan included fusion surgery. No Request for Authorization was submitted to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 laminectomy, L5-S1 pedicle fixation and posterolateral fusion, L5-S1 posterior lumbar interbody fusion using cage autograft, allograft: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The request for L5-S1 laminectomy, L5-S1 pedicle fixation and posterolateral fusion, L5-S1 posterior lumbar interbody fusion using cage autograft, allograft is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends fusion surgery for patients who have evidence of instability and radicular findings consistent with pathology identified on an imaging study that have failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the patient underwent a CT scan on 07/29/2014 that documented there was a retrolisthesis at the L5-S1 indicating evidence of instability. However, the injured worker's most recent clinical evaluation did not provide any justification for the surgical request. Additionally, significant radicular symptoms were not provided. Furthermore, the American College of Occupational and Environmental Medicine recommends patients undergoing a spinal surgery receive a psychological evaluation. The clinical documentation did not include a psychological evaluation of the injured worker to support that they are an appropriate candidate for fusion surgery. As such, the requested L5-S1 laminectomy, L5-S1 pedicle fixation and posterolateral fusion, L5-S1 posterior lumbar interbody fusion using cage autograft, allograft is not medically necessary or appropriate.

**Post-operative with testing per anesthesia protocol:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**Neurosurgery 2 week post-operative follow-up:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**Post-operative lumbar X-ray at 2 week follow up:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**Facility-inpatient, length of stay not specified:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.