

<b>Case Number:</b>	CM15-0012048		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	01/17/2003
<b>Decision Date:</b>	03/18/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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, New Hampshire, Washington  
 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 57 year old female, who sustained an industrial injury on January 17, 2003. The diagnoses have included status post posterior lumbar interbody posterior lumbar decompression and interbody fusion at L5-S1 performed on June 22, 2004, subsequent removal of hardware at L5-S1 on November 2, 2010 and development of spondylolisthesis L4-L5 above fusion with spinal instability and severe spinal stenosis with lower extremity radiculopathy. Treatment to date has included X-ray of lumbar spine, Magnetic resonance imaging on December 11, 2014 revealed grade one spondylolisthesis with severe central and severe foraminal stenosis. Currently, the injured worker complains of incapacitating back pain and radiating leg pain right greater than left with right leg weakness. In a progress note dated December 19, 2014, the treating provider reports severe tenderness, guarding and spasm into the lumbar paraspinal musculature with severe painful loss of range of motion, lower extremity neurologic examination showed positive straight leg raising bilaterally, weakness of L5 and L5 distribution 4/5 of right leg and decreased sensation in L5-S1 distribution of the right leg. On December 31, 2014 Utilization Review non-certified an anterior and posterior fusion at the L4-L5 level, assistant surgeon, surgery clearance and three night inpatient stay, noting, Medical Treatment Utilization Schedule Guidelines, American College of Occupational and Environmental Medicine and Occupational Medical Practice Guidelines, Second Edition was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 anterior and posterior fusion at the L4-L5 level: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM 2nd edition, Chapter Surgical Considerations-Low Back Complaints, Surgical Considerations page(s) 305-306

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-322.

**Decision rationale:** 57 yo female with chronic LBP. MTUS criteria for lumbar fusion not met. There is no documented instability, fracture, or tumor. There are no red flags for spinal fusion surgery in the medical records. Fusion surgery for degenerative low back pain is not more likely than conservative measures to relieve low back pain symptoms.

**Associated Surgical service 1 assistant surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM 2nd edition, Chapter Surgical Considerations-Low Back Complaints, Surgical Considerations page(s) 305-306

**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.