

<b>Case Number:</b>	CM15-0018732		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	08/19/2004
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/02/2015

### 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: Texas  
 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 reported an injury on 08/19/2004 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to her neck and low back. The injured worker exhausted conservative treatment for the low back and spinal fusion surgery was recommended. The injured worker underwent an MRI on 09/03/2014 that identified a grade 1 anterolisthesis of the L2 over the L3, L3 over L4, and L4 over L5. The injured worker was evaluated on 12/18/2014. Examination findings at that appointment included tenderness to palpation of the lumbar paravertebral musculature with limited range of motion secondary to pain and a positive straight leg raising test bilaterally. It was documented that the injured worker had decreased sensation in the L4 through S1 dermatomal distributions bilaterally. The injured worker's diagnoses included cervical discogenic disease, lumbar discogenic disease with radiculopathy, chronic low back pain, and headaches. The injured worker's treatment plan included continuation of medications and lumbar fusion surgery from the L4 to the S1. No request for authorization form 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:

**Anterior Posterior Lumbar Spinal Fusion, Neuromonitoring, Graft L3-L4, L4-L5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Chapter 7: Independent Medical Examinations and Consultations.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

**Decision rationale:** The requested Anterior Posterior Lumbar Spinal Fusion, Neuromonitoring, Graft L3-L4, L4-L5 is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend fusion surgery for instability identified on an imaging study in conjunction with radiculopathy that has failed to respond to conservative treatment. The clinical documentation does indicate that the injured worker has failed to respond to conservative treatment and had instability identified on the imaging study in conjunction with physical findings of radiculopathy. However, the American College of Occupational and Environmental Medicine recommend a psychological evaluation prior to fusion surgery. The clinical documentation does not include a psychological evaluation. Due to the extensive postsurgical rehabilitation of a multilevel fusion, a psychological evaluation prior to surgical intervention would be supported in this clinical situation. As such, the requested Anterior Posterior Lumbar Spinal Fusion, Neuromonitoring, Graft L3-L4, L4-L5 is not medically necessary or appropriate.

**Associated Surgical Service: 3-Day Inpatient Stay:** 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: Assistant Surgeon:** 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.

**Medical Clearance:** 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.