Case Number:	CM15-0073230		
Date Assigned:	04/23/2015	**Date of Injury:**	03/22/2013
Decision Date:	05/20/2015	**UR Denial Date:**	04/03/2015
Priority:	Standard	**Application Received:**	04/17/2015

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 Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 56 year old male, who sustained an industrial injury on March 22, 2013. He reported back pain. The injured worker was diagnosed as having lumbar radiculopathy, spinal stenosis, and status post l4-5 hemilaminectomy in January 2014. Diagnostics to date has included MRI, x-rays, and electrodiagnostic studies. Treatment to date has included a nerve root block of lumbar 4-5, a spinal cord stimulator trial, heat/ice, and medications including pain, muscle relaxant, anti-epilepsy, antidepressant, and non-steroidal anti-inflammatory. On March 26, 2015, the injured worker complains of lower back pain with muscle spasms and left leg pain. His pain was exacerbated when he twisted his right ankle causing severe lumbar muscle spasm and pain down his legs. Associated symptoms include radiating pain and numbness down the left leg. His pain is rated 8-9/10. The physical exam revealed an antalgic gait favoring the left leg, normal heel-to-toe gait, decreased deep tendon reflexes of the left knee and ankle, decreased deep tendon reflexes of the right ankle, lumbar 5 and sacral 1 hypesthesia, and decreased ankle dorsiflexion, ankle inversion, extensor hallucis longus, and anterior tibialis. The treatment plan includes an anterior lumbar interbody fusion of lumbar 5-sacral 1. The requested treatment is an inpatient surgery lumbar 5-sacral 1 anterior lumbar interbody fusion 2-3 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

In-patient surgery L5-S1 anterior lumbar interbody fusion: Upheld

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

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

Decision rationale: According to MTUS guidelines, "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 non-fusion group (a 15% greater chance of being "much better") versus a 17% complication rate (including 9% life-threatening or reoperation)." There is no clear evidence of spinal fracture, dislocation, or spondylolisthesis or spine instability. Therefore, the request for In-patient surgery L5-S1 anterior lumbar interbody fusion is not medically necessary.