

<b>Case Number:</b>	CM15-0101757		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	10/05/2012
<b>Decision Date:</b>	07/17/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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  
 Certification(s)/Specialty: Neurological 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 37 year old male, who sustained an industrial injury on October 5, 2012. The injury occurred while working as a laborer. The injured worker has been treated for low back complaints. The diagnoses have included spondylolisthesis and lumbar five-sacral one disc protrusion. Treatment to date has included medications, radiological studies and MRI. Prior conservative treatments were not found in the documentation. Current documentation dated May 7, 2015 notes that the injured worker reported low back pain worse with movement. Examination of the lumbar spine revealed tenderness and a decreased range of motion. The injured worker experienced no pain with range of motion. Sensation was normal throughout with exception of lumbar-five diminished sensation. Motor examination was normal in all major muscle groups and bilateral lower extremities. The treating physician recommended a lumbar fusion due to lumbar five-sacral one spondylolisthesis and persistent deficit in the lumbar five-sacral one level. The treating physician's plan of care included a request for a lumbar five-sacral one anterior lumbar interbody fusion, neuromonitoring, laboratory studies, chest x-ray, approach surgeon, lumbar-sacral orthosis back brace and Percocet 10/325 mg # 60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 Anterior lumbar interbody fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 13th edition (web), 2015, Low Back, Fusion.

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

**Decision rationale:** The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. Documentation notes a minimal spondylolisthesis at L5-S1 with no evidence of pathologic instability. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: L5-S1 Anterior lumbar interbody fusion is not medically necessary and appropriate.

**Associated surgical services: Neuromonitoring:** 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 services: CBC, CMP, EKG, PT, PTT, INR:** 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 services: Chest x-ray:** 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.

**Approach 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.

**Associated surgical services: LSO Back brace:** 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.

**Percocet 10/325mg #60:** 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.