

<b>Case Number:</b>	CM15-0102014		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	06/20/2014
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/11/2015
<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:

This 36 year old male sustained an industrial injury to the low back on 6/20/14. The injured worker underwent lumbar decompression and laminectomy in July 2014. Magnetic resonance imaging lumbar spine (10/14/14) showed early degenerative disease at L4-S1 and status post foraminotomy on the left L5-S1 with no evidence of neural impingement. In a PR-2 dated 5/4/15, the physician noted that the magnetic resonance imaging from 10/14/14 showed status post foraminal decompression and severe lumbar radicular syndrome. X-rays of the lumbar spine (3/9/15) showed lumbar disc space narrowing at L5 to S1. The physician noted that the injured worker had been getting worse with severe low back pain and left lower extremity symptoms that he rated at 10/10 on the visual analog scale without medications and 8/10 with medications. The injured worker had left foot drop and ongoing numbness and tingling in the left lower extremity. Physical exam was remarkable for normal reflex, sensory and power testing to bilateral upper and lower extremities except 4/5 weakness and numbness at left L5 distribution with positive straight leg raise and bowstring on the left, a marked antalgic gait and left foot drop. Current diagnoses included left foraminal herniated nucleus pulposus and status post decompression and laminectomy. The treatment plan included anterior lumbar arthrodesis including discectomy including lateral retroperitoneal approach technique, revision decompression L5-A1 anterior lumbar instrumented fusion with allograft, cage, and plate at L5-S1 with associated surgical services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior lumbar arthodesis including discectomy including lateral retroperitoneal approach technique, revision decompression L5-A1 anterior lumbar instrumented fusion with allograft, cage, plate at L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-7.

**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. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. Therefore, the requested anterior lumbar arthodesis including discectomy including lateral retroperitoneal approach technique, revision decompression L5-A1 anterior lumbar instrumented fusion with allograft, cage, plate at L5-S1 is not medically necessary and appropriate.

**Associated surgical service: Three day inpatient hospital 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.

**Associated surgical service: 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.

**Associated surgical service: Psychiatric evaluation:** 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.

**Post operative physical therapy, twice a week for six weeks:** 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: Hot/cold therapy unit:** 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: Bone growth stimulator:** 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: 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.

**Associated Surgical Service: Muscle stimulator:** 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 #100:** 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.

**Ambien 10mg #30:** 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.