

<b>Case Number:</b>	CM15-0187055		
<b>Date Assigned:</b>	10/01/2015	<b>Date of Injury:</b>	12/13/2011
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2015

### **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, Montana, California  
 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 51 year old male, who sustained an industrial-work injury on 12-13-11. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar intervertebral disc displacement without myelopathy and sciatica. Medical records dated (5-4-15 to 8-19-15) indicate that the injured worker complains of low back pain rated 6-7 out of 10 on the pain scale and constant numbness and burning of the posterior and lateral right leg. He reports that any activity aggravates his condition and nothing seems to make it better. Per the treating physician report dated 8-20-15 the injured worker has not returned to work. The physical exam dated 8-19-15 reveals tenderness at the lumbosacral region with moderate to severe decreased range of motion secondary to back pain, right lower extremity (RLE) numbness and tingling. The lower extremity exam reveals 4 out of 5 strength in the right ankle dorsiflexion with decreased sensation in the right foot dorsum and he walks independent with an antalgic gait favoring the right. The physician indicates that he recommends surgical intervention. Treatment to date has included pain medication including Norco, diagnostics, physical therapy with some relief, activity modifications and other modalities. Magnetic resonance imaging of the lumbar spine dated 6-29-15 reveals mild multi-level degenerative changes of the lumbar intervertebral discs and facets causing mild bilateral L4-L5 and L5-S1 neural foraminal narrowing. EMG-NCV (electromyography and nerve conduction velocity) testing was performed on 12-10-12 reveals bilateral L5 radiculopathies and right S1 radiculopathy. X-Ray of the lumbar spine dated 6-29-15 reveals mild degenerative disc disease (DDD) L4-5 level. The request for authorization date was 8-24-15 and requested services included L4-5 lumbar lateral interbody fusion, L5-S1 AXIALIF,

LOS: inpatient stay x3 days, Post op purchase lumbar brace, Post op purchase orthofix bone growth stimulator, Post op rental vascultherm cold therapy unit x14 days, Post op physical therapy 2x6 to the lumbar spine, Post op lumbar X-rays x3 to be completed at post op visits x3, Pre op lab: CBC with diff, Pre op labs: CMP, Post op labs PT-PTT, Pre op labs UA, Pre op exam with internal medicine, Pre op Electrocardiogram (EKG) , Assistant surgeon, Intraoperative neuropsychophysiological monitoring, and Pre op Chest X-ray if needed. The original Utilization review dated 9-9-15 non-certified the request for L4-5 lumbar lateral interbody fusion, L5-S1 AXIALIF, LOS: inpatient stay x3 days, Post op purchase lumbar brace, Post op purchase orthofix bone growth stimulator, Post op rental vascultherm cold therapy unit x14 days, Post op physical therapy 2x6 to the lumbar spine, Post op lumbar X-rays x3 to be completed at post op visits x3, Pre op lab: CBC with diff, Pre op labs: CMP, Post op labs PT-PTT, Pre op labs UA, Pre op exam with internal medicine, Pre op Electrocardiogram (EKG) , Assistant surgeon, Intraoperative neuropsychophysiological monitoring, and Pre op Chest X-ray if needed.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **L4-5 lumbar lateral interbody fusion, L5-S1 AXIALIF: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of this. His magnetic resonance imaging scan (MRI) showed no severe canal or foraminal stenosis or nerve root impingement. His provider recommended a lateral interbody lumbar arthrodesis. Documentation does not present evidence of instability. According to the Guidelines for the performance of fusion procedures for degenerative diseases of the lumbar spine, published by the joint section of the American Association of Neurological surgeons and Congress of Neurological surgeons in 2005 there was no convincing medical evidence to support the routine use of lumbar fusion at the time of primary lumbar disc excision. This recommendation was not changed in the update of 2014. The update did note that fusion might be an option if there is evidence of spinal instability, chronic low back pain and severe degenerative changes. Documentation does not show instability or severe degenerative changes. The requested treatment: L4-5 lumbar lateral interbody fusion, L5-S1 AXIALIF is not medically necessary and appropriate.

**LOS: inpatient stay x3 days: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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 op purchase lumbar brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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 op purchase orthofix bone growth stimulator:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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 op rental vascutherm cold therapy unit x14 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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 op physical therapy 2x6 to the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

**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 op lumbar X-rays x3 to be completed at post op visits x3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**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.

**Pre op lab: CBC with diff:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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.

**Pre op labs: CMP:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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 op labs PT/PTT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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.

**Pre op labs UA:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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.

**Pre op exam with internal medicine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on

the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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.

**Pre op EKG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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.

**Assistant surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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: Intraoperative neurophysiological monitoring:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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.

**Pre op Chest X-ray if needed:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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.