

<b>Case Number:</b>	CM15-0189609		
<b>Date Assigned:</b>	10/01/2015	<b>Date of Injury:</b>	03/22/2013
<b>Decision Date:</b>	11/13/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2015

### 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  
 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 53 year old male who sustained an industrial injury on 3-22-13. A review of the medical records indicates he is undergoing treatment for lumbar radiculopathy with left lower extremity deficit (foot drop), status post L4-L5 laminectomy and L5-S1 hemilaminectomy on 1-15-14, bilateral L5 foraminal stenosis secondary to disc degeneration and segmental collapse - residual versus recurrent status post decompressive surgery, post laminectomy syndrome, and probable tensor fasciae latae sprain. Medical records (3-27-15 to 8-31-15) indicate ongoing complaints of left-sided low back pain with muscle spasms and pain radiating down left leg, as well as associated numbness. He rates the pain "5-6 out of 10" (8-31-15). The physical exam (7-27-15) reveals tenderness to palpation on bilateral paraspinal muscles in the thoracic and lumbar spine. Range of motion is diminished on the right side. Straight leg raising test is negative bilaterally. Bilateral quadriceps strength is noted to be "4+ out of 5". Diagnostic studies since his previous surgery have included an MRI of the left knee on 4-16-14, MRI of the lumbar spine on 5-20-14 and 3-16-15, EMG-NCV on 10-10-14, and x-rays of the left ankle. Treatment has included physical therapy, chiropractic treatments, a home exercise program, one epidural steroid injection, and a spinal cord stimulator. He is currently (8-31-15) not working. He has also had use of a raised toilet seat and a wheeled walker to assist with activities of daily living (4-3-15). A request was made for aqua therapy. However, this authorization is pending. Effects of his symptoms on activities of daily living include limitations in going out of the house, household chores, dressing, prolonged standing, bending or kneeling, getting out of a chair, turning over in bed, donning clothing, including socks and shoes,

disturbed sleep, and difficulty using the stairs. The treatment recommendations include an anterior lumbar fusion at L5-S1. The utilization review (9-15-15) includes requests for authorization of anterior lumbar fusion at L5-S1 with assistance of surgeon and 3-day length of stay. The service was denied.

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

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

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

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

**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. The patient's magnetic resonance imaging scan (MRI) showed no severe canal or foraminal stenosis or nerve root impingement. His provider recommended an anterior interbody lumbar arthrodesis to treat his lumbago. Documentation does not present evidence of instability or radiculopathy. 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 California MTUS guidelines recommend lumbar surgery if there is severe persistent, debilitating lower extremity complaints, clear clinical and imaging evidence of a specific lesion corresponding to a nerve root or spinal cord level, corroborated by electrophysiological studies which is known to respond to surgical repair both in the near and long term. Documentation does not provide this evidence. The requested treatment: Anterior lumbar fusion at L5-S1 is not medically necessary and appropriate.

**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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical service: 3 day inpatient length of 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-op Labs: CMP:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-op Labs: CBC:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-op Labs: PT/PTT:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-op Labs: EKG:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical service: Vascular surgeon consult:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.