

<b>Case Number:</b>	CM15-0215534		
<b>Date Assigned:</b>	11/09/2015	<b>Date of Injury:</b>	03/01/2011
<b>Decision Date:</b>	12/21/2015	<b>UR Denial Date:</b>	10/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/02/2015

### 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 47 year old male with a date of injury on 03-01-2011. The injured worker is undergoing treatment for post lumbar laminectomy syndrome, L4-5 and L5-S1 spondylosis-annular tear and discogenic low back pain, and degenerative disc disease. A physician note dated 07-17-2015 documents the injured worker has complaints of continued increasing low back pain and pain and tingling in his left leg. Lumbar range of motion is restricted and straight leg raise is positive ipsilateral and associated with bilateral increased leg pain. A physician progress note dated 08-28-2015 documents the injured worker has complaints of lower back pain radiating to his left hip. He has had some recurrent left sciatica, and his symptoms are worse with sleep and interfere with his ADLs. He sleeps a maximum of 3 to 4 hours a night. Lumbar range of motion is restricted and straight leg raising is positive ipsilateral. Neurologic exam of the lower extremities is intact with regard to motor strength, sensation and deep tendon reflexes. The physician documents "she is in need of anterior fusion." "Surgery is necessary since he has quality of life issues, reduced activities of daily living, sleep disturbance and symptoms referable to the lower back that matches up with his pathology both clinically and radio- graphically." He continues to work. Treatment to date has included diagnostic studies, medications, bilateral S1 injection for greater than 50% relief ongoing decreasing it down to a 3 out of 10, status post L5-S1 microdiscectomy in 05-2013, physical therapy, status post left shoulder surgery x 2, use of a back brace, and home exercise program. A Magnetic Resonance Imaging of the lumbar spine done on 11-07-2015 reveals L4-5 mild spinal canal narrowing with mild bilateral neural foraminal narrowing. Post-surgical changes are noted in the posterior

paraspinal soft tissues. At L5-S1 there is mild spinal canal narrowing with mild-moderate left inferior neural foraminal narrowing. Current medications include Gabapentin, Norco, and Advil. The Request for Authorization dated 10-05-2015 includes L4-5 and L5-S1 anterior lumbar interbody fusion, Associated surgical service: 3 day inpatient stay, Associated surgical service: DJO Bone growth stimulator, Associated surgical service: Assistant surgeon Associated surgical service: Medical clearance, and Post-op lumbar brace. On 10-12-2015 Utilization Review non-certified the request for L4-5 and L5-S1 anterior lumbar interbody fusion, Associated surgical service: 3 day inpatient stay, Associated surgical service: DJO Bone growth stimulator, Associated surgical service: Assistant surgeon, Associated surgical service: Medical clearance, and Post-op lumbar brace.

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

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

#### **L4-5 and L5-S1 anterior lumbar interbody fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back - Fusion (spinal).

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

**Decision rationale:** The California MTUS guidelines recommend lumbar 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. California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of these conditions. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: L4-5 and L5-S1 anterior lumbar interbody fusion is not medically necessary and appropriate.

#### **Associated surgical service: 3 day inpatient 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: DJO 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.

**Post-op lumbar 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.