

<b>Case Number:</b>	CM15-0034055		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	12/12/2012
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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  
 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 58-year-old male, who sustained an industrial injury on 12/12/12. He reported low back pain that radiated to the left leg and into the left foot. The injured worker was diagnosed as having sprain/strain of the sacroiliac joint, degenerative lumbar/lumbosacral, acquired spondylolisthesis, and displaced lumbar intervertebral disc. Treatment to date has included physical therapy, an epidural steroid facet injection, and medications including Ultram, Percocet, and Soma. Currently, the injured worker complains of low back pain. The treating physician requested authorization for L5-S1 posterior interbody decompression and fusion, allografting and any repairs, arthrodesis posterior or posterolateral technique single level lumbar, posterior segmental instrumentation, fluoroscopy, inpatient-assist GP/Ortho, pre-operative medical clearance, pre-operative chest x-ray, pre-operative labs (CBC, BMP, UA, PT/PTT, TSH), intra-operative monitoring, cell saver, post-operative walker, post-operative physical therapy for the lumbar spine 3 times weekly, post-operative Norco 10/325mg, inpatient stay (unspecified), and pre-operative EKG. Rational for the requested services was not provided in the medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 Posterior Interbody Decompression and Fusion, Instrumentation, Allografting with any repairs, Arthrodesis, Posterior or Posterolateral Technique under Fluoroscopy: 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, 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 does not show evidence of movement at the patient's spondylolisthesis. The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. Documentation does not disclose disabling lower extremity symptoms. This proposed surgery was initially approved in 2013, but then for whatever reasons, it was not scheduled until December 2014. The guidelines also list the criteria for surgery should be for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion, which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The requested treatment is for L5-S1 posterior interbody decompression and fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment L5-S1 posterior interbody decompression and fusion is not medically necessary and appropriate.

**Inpatient-assist GP/Ortho: 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.

**Pre-Operative 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.

**Pre-Operative 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.

**Pre-Operative Labs (CBC, BMP, UA, PT/PTT, TSH):** 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.

**Intra-Operative Monitoring:** 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.

**Cell Saver:** 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 Walker:** 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 (12-sessions, 3 times a week for 4 weeks for the lumbar spine): 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 Norco 10/35mg, #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.

**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.

**Pre-Operative 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.