

<b>Case Number:</b>	CM15-0039425		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	07/07/2014
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	01/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/02/2015

### 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

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 37-year-old male who sustained an industrial injury on 7/7/14 from a lifting incident resulting in a burning pain in the low back that radiates to the testicles. He had lumbar x-ray and testicular ultrasound. He currently complains of severe low back pain radiating down legs, buttocks, dorsal aspect of foot and also radiating into testicle. He has decreased range of motion. Pain intensity is 7/10. Medications are Tramadol, Baclofen, carisoprodol, cefuroxime axetil, hydrocodone, and naproxen. Diagnoses include low back pain; spinal stenosis of lumbar region; lumbosacral radiculitis. Treatments to date include pain medication, physical therapy, bilateral L5-S1 transforaminal epidural steroid injection (11/17/14) with temporary relief. Diagnostics include lumbar spine x-ray (7/8/14) showing degenerative changes and small anterior posterior L5 spur formation; testicular ultrasound (7/16/14) normal study; MRI of the lumbar spine (9/30/14) with severe degeneration at L5-S1 resulting in moderate foraminal stenosis and disc herniation; x-ray lumbosacral spine (10/27/14) abnormal. In the progress note dated 1/20/15, the treating provider's plan of care indicated that due to minimal improvement with conservative measures and residual ongoing symptoms surgical intervention is requested as lumbar decompression at L5-S1 with fusion and instrumentation and associated post-operative issues.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 Anterior Lumbar Interbody Fusion with Hardware with Possible Posterior Decompression, Fusion, and Instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines, 13th Edition, Web, Low Back, 2015, Fusion.

**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. The guidelines also list the necessity for surgical consideration the presence of 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 an anterior lumbar interbody fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. Therefore, the request is not medically necessary and appropriate.

**Associated surgical service: 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.

**Pre-Operative 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: 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: Hospital Stay, 2 days:** 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: 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: 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: 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..

**Post-Operative Physical Therapy:** 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.