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| <b>Case Number:</b>   | CM15-0049242 |                              |            |
| <b>Date Assigned:</b> | 04/15/2015   | <b>Date of Injury:</b>       | 11/02/2012 |
| <b>Decision Date:</b> | 05/08/2015   | <b>UR Denial Date:</b>       | 03/05/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/16/2015 |

### 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 61 year old male who sustained an industrial injury on November 2, 2012. The injured worker was diagnosed with lumbar spondylolisthesis and stenosis. Treatment to date includes diagnostic testing, surgery, physical therapy, lumbar corset brace, cane for ambulation and medications. The latest magnetic resonance imaging (MRI) is dated January 23, 2015. The injured worker is status post an anterior L4-S1 spinal fusion on February 20, 2014. According to the treating physician's progress report on February 16, 2015, the injured worker continues to experience increasing pain radiating bilaterally to the buttocks, legs, left groin with numbness and tingling across the anterior left thigh to the knee. Examination of the lumbar spine demonstrated decreased left quadriceps strength and decreased left hip adductor strength with a positive straight leg raise at 90 degrees. Current medications were not listed. The current treatment plan consists of direct lateral discectomy and fusion at L3-4 along with pre-operative and post-operative associated services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Direct lateral discectomy and fusion at L3-4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back-Lumbar and Thoracic (Acute and Chronic).

**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 a traumatic fracture or dislocation. Documentation does not show abnormal movement at L3-4 where the 7mm retrolisthesis is described. The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation shows this patient has been complaining of pain in the buttocks legs and groin. Straight leg rising was noted to be negative and no weakness was found on the office visit of 1/12/2015, but left leg weakness was noted on 2/16/15. Documentation does not disclose disabling lower extremity symptoms. The guidelines also list the criteria 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 a direct lateral discectomy and L3-4 fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: 1 Direct lateral discectomy and fusion at L3-4 Is / are NOT Medically necessary and appropriate.

**Associates surgical service: 1 Inpatient stay for 3 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 (ODG), Low Back-Lumbar and Thoracic (Acute and Chronic).

**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.

**Associates surgical service: 1 Assistant surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Centers for Medicare & Medicaid Services (CMS).

**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.

**Associates surgical service: 1 Spinal cord 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 (ODG).

**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.

**1 Pre-operative physical and 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.

**1 Pre-op labs: CBC with diff, CMP, PT, PTT, UA, MRSA:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvements (ICSI) Official Disability Guidelines (ODG), Low Back-Lumbar and Thoracic (Acute and Chronic).

**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.

**Associates surgical service: 1 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.

**Associates surgical service: 1 EKG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI), Preoperative evaluation.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the requested treatment: 1 Direct lateral diskectomy and fusion at L3-4 Is / are NOT Medically necessary and appropriate, then the Requested Treatment: Associates surgical service: 1 EKG is NOT Medically necessary and appropriate.

**Associates surgical service: 1 LSO back 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 (ODG), Low Back-Lumbar and Thoracic (Acute and Chronic), Back brace, post operative (fusion).

**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.