

<b>Case Number:</b>	CM15-0050915		
<b>Date Assigned:</b>	04/15/2015	<b>Date of Injury:</b>	12/09/2003
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	02/18/2015
<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 12/9/03. The injured worker was diagnosed as having lumbar strain with radiculopathy, right knee sprain/strain, status post right knee arthroscopy, right knee patellofemoral chondromalacia and patellofemoral subluxation, left knee sprain/strain with patellofemoral chondromalacia and subluxation and (MRI) magnetic resonance imaging evidence of anterior cruciate ligament tear. Treatment to date has included epidural steroid injections, chiropractic treatment, acupuncture, physical therapy, right knee arthroscopy, oral medications and home exercise program. Currently, the injured worker complains of intermittent low back pain with numbness in both posterior aspects of legs and feet. The injured worker stated the right knee injection received on previous visit helped greatly with decreasing pain. Physical exam noted tenderness to palpation at L5-S1 bilaterally as well as the para vertebral musculature, muscle and restricted range are also noted; examination of the right knee revealed no tenderness to palpation, left tenderness to palpation is noted over the medial joint line with decreased quadriceps strength. The treatment plan included prescriptions for ibuprofen and omeprazole, home exercises and lumbar spine surgery. A request for authorization was submitted for anterior lumbar inter body fusion, vascular surgeon, assistant surgeon, cybertech brace for post op use, pre-op medical clearance, post op cryotherapy and one month at 3-5 times per day bone simulator.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior Lumbar Interbody Fusion at the L4-L5 and L5-S1 levels with Decompression Foraminotomy at the L5-S1 level: 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. The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling shoulder lower extremity symptoms. The documentation shows this patient has been complaining of pain in the back and numbness in his legs. 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 an anterior lumbar interbody fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment Anterior Lumbar Interbody Fusion at the L4-L5 and L5-S1 levels with Decompression Foraminotomy at the L5-S1 level is NOT medically necessary and appropriate.

**Vascular 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.

**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.

**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.

**Purchase of Lumbar Cybertech 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.

**1 month Rental of Cryotherapy 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.

**6 weeks Rental of Bone 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.