

<b>Case Number:</b>	CM15-0079742		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	01/27/2014
<b>Decision Date:</b>	08/04/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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: California  
 Certification(s)/Specialty: Orthopedic 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, with a reported date of injury of 01/27/2014. The diagnoses include lumbar spine radiculopathy and discopathy, lumbar spine sprain, and L4-5 central and foraminal stenosis. Treatments to date have included oral medications, and computerized tomography (CT) scan of the lumbar spine. The follow-up report dated 02/18/2015 indicates that the injured worker had remained on temporary total disability since 08/18/2014. The injured worker stated that his lower back condition had not changed very much in terms of pain, stiffness, irritation of motion, and stability. His pain level remained at a rate of 7-8 out of 10. The injured worker also stated that he still had ongoing severe pain, numbness, tingling, and weakness of his left low extremity, with radiation down to his foot. He also complained of left sciatic pain, rated 7-8 out of 10. He has limited activities of daily living. The physical examination showed an inability to stand straight, a slight limp, inability to stand on his heel or toes, a present right single-foot heel-raise, but absent on the left, flattening of the lumbar lordosis, increased muscle tone of the paraspinal muscles of the lumbar spine, diffuse tenderness of the lumbar spine to pressure palpation, irritation to palpation of the left sciatic notch, non-tender to palpation of the right sciatic notch, and limited lumbar range of motion and muscle spasm. The treating physician requested anterior/posterior 360 degree lumbar fusion with pedicle screw at L4-5 and L5-S1, three-day inpatient stay, pre-operative medical clearance, assistant surgeon, vascular co-surgeon, pre-operative chest x-ray, and pre-operative EKG.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior/posterior 360 degrees Lumbar fusion w/ pedicle screw L4-5 & L5-S1:** 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): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion.

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. "According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In lumbar fusion patients smoking cessation for 6 weeks is recommended. In this particular patient there is lack of medical necessity for lumbar fusion as there is no lack of evidence of smoking cessation or psychiatric clearance from the exam note of 2/18/15 to warrant fusion. Therefore, the request is not medically necessary.

**Associated surgical service: 3 days in-patient stay:** 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, Hospital length of stay (LOS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Fusion, Hospital Length of Stay.

**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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back - Surgical assistant.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aaos.org/about/papers/position/1120.asp>.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Vascular co-surgeon:** 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 - Surgical assistant.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aaos.org/about/papers/position/1120.asp>.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre op Chest X-ray:** 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 - Preoperative testing, general.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative testing.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre op Electrocardiogram (EKG):** 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 - Preoperative testing, general.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative testing.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre op Medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.guideline.gov/content.aspx?id=48408>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative testing.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.