

<b>Case Number:</b>	CM15-0083614		
<b>Date Assigned:</b>	05/08/2015	<b>Date of Injury:</b>	12/28/2009
<b>Decision Date:</b>	06/05/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2015

### 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 50-year-old male who sustained an industrial injury on 12/28/2009. The injured worker was diagnosed with chronic low back pain and degeneration of the lumbar intervertebral disc. The injured worker is status post anterior fusion at L5-S1 with ventral plate screws and interbody fusion plug in April 2011. Treatment to date includes diagnostic testing with a recent lumbar myelogram and Computed Tomography (CT) of the lumbar spine on March 26, 2015, physical therapy, assistive devices, trigger point injections, Toradol injections intermittently and medications. According to the primary treating physician's progress report on March 30, 2015, the injured worker continues to experience low back and right leg pain. The injured worker ambulates with a cane. Examination of the lumbar spine demonstrated mild pain on palpation of the lower lumbar spine without spasm. There is a discrepancy about an antalgic gait, heel and toe ambulation and focal deficits. Range of motion was decreased in all directions with negative straight leg raise bilaterally; negative Faber and severe tension signs right leg were noted. Normal sensation was noted in the bilateral lower extremities. Current medications are listed as Norco, Flexeril, Gabapentin, Prozac and Pantoprazole. Treatment plan consists of pain management referral and the current request for an anterior lumbar interbody fusion L4-5 and right L5 foraminotomy with bone growth stimulator, associated services for assistant and co assistant surgeon, consultation with co-surgeon, in-patient 2 day stay, medical clearance consultation, diagnostic work-up pre-operatively including blood work, chest X-ray and Electrocardiogram (EKG) and lumbar back brace.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **ALIF L4-5 and Right L5 Foraminotomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM 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. Radiologist does not report any pathologic instability on flexion and extension views. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. Therefore, the request is not medically necessary and appropriate.

### **Associated Surgical Service: Inpatient 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: Co-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: Consult with Co-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: 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: Lumbar 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: Medical Clearance Appointment:** 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-Op Labs: CBC, CMP, PT, PTT, INR, UA, EKG, 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.