

<b>Case Number:</b>	CM15-0107996		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	06/10/2012
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2015

### 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 48 year old female, who sustained an industrial injury on June 10, 2012. The injury occurred when a resident grabbed the injured workers left arm and pushed her into a table. The injured worker has been treated for low back complaints. The diagnoses have included lumbago, lumbar disc herniation, lumbar degenerative disc disease and lumbar sprain/strain. Treatment to date has included medications, radiological studies, physical therapy, injections, braces, and a home exercise program. Current documentation dated April 30, 2015 notes that the injured worker reported low back pain which radiated into the bilateral lower extremities with associated weakness, numbness and tingling. Examination of the lumbar spine revealed severe tenderness to palpation over the paraspinal muscles. Lumbar spine range of motion was noted to be decreased. A straight leg raise caused low back pain. Sensation was noted to be intact. The treating physician recommended a lumbar fusion. The treating physician's plan of care included a request for an anterior lumbar decompression and fusion of lumbar four-lumbar five, lumbar four-lumbar five anterior instrumentation, application of intervertebral disc biomechanical devices, lumbar four-lumbar five allograft, assistant surgeon, pre-operative laboratory work and a pre-operative electrocardiogram.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior lumbar decompression and fusion L4-5: 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): 305-07.

**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. Documentation is not provided to support any of these diagnoses. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested anterior lumbar decompression and fusion L4-5 is not medically necessary and appropriate.

**L4-5 anterior instrumentation: 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.

**Application of intervertebral biomechanical devices: 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.

**L4, L5 allograft: 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.

**Pre-operative CBC, CMP, protime, PTT, MRSA:** 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 EKG:** 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.