

<b>Case Number:</b>	CM15-0119476		
<b>Date Assigned:</b>	07/06/2015	<b>Date of Injury:</b>	07/02/2014
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	06/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/22/2015

### 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 63 year old male, who sustained an industrial injury on 7/02/14. He reported low back pain. The injured worker's initial diagnosis was not included. Treatment to date has included surgical intervention, MRI, epidural steroid injection, facet block injection, medication, x-ray, and physical therapy. Currently, the injured worker complains of radicular pain down the back of his right lower extremity to the knee, right leg weakness. The pain is constant and moderate, but occasionally severe. The pain radiates down the back of his legs to the calves (right side greater than the left) associated with numbness and tingling. He reports leg weakness as well as stiffness, tightness and decreased range of motion in his low back. The low back pain is increased with prolonged sitting, walking, bending, lying down, and using stairs. He also reports sleep disturbance due to pain. He is diagnosed with lumbar sprain, lumbar disc degeneration, facet arthropathy and cervical stenosis. His work status is temporarily and partially disabled with restrictions. A note dated 6/4/15 states the injured worker is unable to walk, sit or stand for greater than 5 minutes due to increased pain. The note also states there is decreased range of motion in the lumbar spine, he experiences difficulty supporting himself on his heels and toes and is experiencing difficulty engaging in activities of daily living due to pain. On examination there are positive nerve root signs, motor weakness, reduced range of motion and decreased sensation along L5-S1. The injured worker reported pain relief from the epidural steroid and facet block injections for approximately 3-4 days, but the pain came back and he experienced weakness in the right leg, per note dated 2/25/15. A note dated 12/19/14 states the injured worker experienced temporary relief from physical therapy. The following, anterior

lumbar interbody fusion L4-L5, L5-S1, assistant surgeon, in-patient hospital stay 3-4 days, pre-operative evaluation and thoracic lumbosacral orthotic brace (associated surgical service), are being requested to help alleviate the injured workers pain and improve his range of motion.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Anterior lumbar interbody fusion 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): 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 guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: Anterior lumbar interbody fusion L4-5, L5-S1 is not medically necessary and appropriate.

**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: In Patient Hospital Stay, 3-4 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: Pre-operative evaluation: 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: Thoracic Lumbo-Sacral Orthotic 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.