

<b>Case Number:</b>	CM15-0039923		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	10/12/2010
<b>Decision Date:</b>	04/15/2015	<b>UR Denial Date:</b>	02/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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:

According to progress note of February 2, 2015, the injured workers chief complaint was lower back pain. The surgeon reviews the new MRI of the lumbar spine and X-rays of the lumbar spine. The injured worker had decreased range of motion of the lumbar spine with spasms. The straight leg was positive on the left lower extremity. There was decreased sensation at L5 dermatome affecting the bilateral lower extremities. The MRI showed severe degenerative disc disease at L4-L5 and L5-S1 with severe foraminal stenosis. The x-ray of the lumbar spine showed flex extension 6mm instability. The injured worker was diagnosed with lumbar spinal stenosis, lumbar radiculopathy and severe degenerative disc disease at L4-L5 and L5-S1. The injured worker previously received the following treatments thoracic facet epidural steroid injection on August 21, 2014 and MRI of the lumbar spine January 2, 2015. The treatment plan included anterior decompression and interbody stabilization at L4-L5 and L5-S1, assistant surgery, surgery clearance with [REDACTED], EKG (Electrocardiography), chest x-ray, laboratory studies (chemistry panel, complete blood count with differential, prothrombin time, PTT INR, and urine analysis and back brace on February 12, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior Lumbar Decompression & Interbody Stabilization at (Lumbar) L4-5 & L5-S1 (Sacroiliac): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-328.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305,307.

**Decision rationale:** According to the California MTUS guidelines, surgical consultation is indicated for patients who have severe and disabling lower leg symptoms with clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short and long term from surgical repair. The patient's MRI scan of 1/02/2015 shows no interval change from the scan of 12/12/2012. In addition, the MTUS guidelines note that spinal fusion is recommended for patients with traumatic fracture, dislocation and instability with progressive neurologic dysfunction. Documentation does not give evidence that this is the case. The requested treatment: anterior lumbar decompression and interbody stabilization at lumbar L4-5 &L5-S1 (sacroiliac) is not medically indicated and appropriate.

**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: Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: anterior lumbar decompression and interbody stabilization at lumbar L4-5 &L5-S1 (sacroiliac) is not medically indicated and appropriate, then the Requested Treatment: Assistant Surgeons is not Medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: anterior lumbar decompression and interbody stabilization at lumbar L4-5 &L5-S1 (sacroiliac) is not medically indicated and appropriate, then the requested treatment, assistant surgeons, is not medically necessary and appropriate.

**Surgery 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 Since the requested treatment: anterior lumbar decompression and interbody stabilization at lumbar L4-5 &L5-S1 (sacroiliac) is not medically indicated and appropriate, then the Requested Treatment: Surgery clearance is not Medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: anterior lumbar decompression and interbody stabilization at lumbar L4-5 &L5-S1 (sacroiliac) is not medically indicated and appropriate, then the requested treatment, surgery clearance, is not medically necessary and appropriate.

**EKG (electrocardiogram)/Chest Xray & Lab work (Chem Panel, CBC [complete blood count] with difference, PT/PTT [prothrombin time/partial thromboplastin time] INR and UA [urinalysis]):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: anterior lumbar decompression and interbody stabilization at lumbar L4-5 &L5-S1 (sacroiliac) is not medically indicated and appropriate, then the Requested Treatment EKG (electrocardiogram)/ Chest X-ray & Lab work (Chem Panel, CBC [complete blood count] with difference, PT/PTT prothrombin : is not Medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: anterior lumbar decompression and interbody stabilization at lumbar L4-5 &L5-S1 (sacroiliac) is not medically indicated and appropriate, then the requested treatment, EKG (electrocardiogram)/ Chest X-ray & Lab work (Chem Panel, CBC [complete blood count] with difference, PT/PTT prothrombin, is not medically necessary and appropriate.

**LSO (lumbosacral) Back Brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since the requested treatment: anterior lumbar decompression and interbody stabilization at lumbar L4-5 &L5-S1 (sacroiliac) is not medically indicated and appropriate, then the Requested Treatment LSO (lumbosacral) Back Brace: is not Medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: anterior lumbar decompression and interbody stabilization at lumbar L4-5 &L5-S1 (sacroiliac) is not medically indicated and appropriate, then the requested treatment, LSO (lumbosacral), back brace is not medically necessary and appropriate.