

<b>Case Number:</b>	CM15-0092170		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	10/30/2013
<b>Decision Date:</b>	06/17/2015	<b>UR Denial Date:</b>	04/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2015

### 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:

This 51 year old male sustained an industrial injury to the low back on 10/30/13. Previous treatment included magnetic resonance imaging, electromyography, physical therapy, epidural steroid injections and medications. Magnetic resonance imaging lumbar spine (2/13/15) showed multilevel lower lumbar spine degenerative disc disease with a posterior disc bulge touching the right L5 nerve root and mild multilevel lower lumbar joint facet osteoarthritis. X-ray of the pelvis (2/28/15) showed no abnormalities. X-ray lumbar spine (2/28/15) showed moderate narrowing of the L4-5 and L5-S1 disc spaces. In a progress note dated 4/14/15, the injured worker complained of ongoing low back pain with radiation to the right lower extremity, rated 6/10 on the visual analog scale with medications and 8/10 without medications. Physical exam was remarkable for physical exam was remarkable for normal lumbar lordosis, normal lumbar spine range of motion, 4/5 strength to the right peroneal and extensor hallucis longus muscles and decreased sensation to the right first web space and plantar area of the foot. Current diagnoses included lumbosacral neuritis, acquired spondylolisthesis and displaced lumbar intervertebral disc. The physician noted that the injured worker was experiencing progressively worsening lumbar and radicular pain associated with difficulty with gait and stability. The physician noted that the injured worker was a fall risk. The injured worker had failed 16-18 sessions of physical therapy to the lumbar spine and numerous epidural steroid injections, obtaining only short term relief. The treatment plan included L4-5 anterolateral discectomy and fusion with associated surgical services.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Anterolateral L4-5 Discectomy & Fusion Qty 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**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: Anterolateral L4-5 Discectomy & Fusion Qty 1 is NOT Medically necessary and appropriate.

### **L4-5 Posterior instrumented Fusion Qty 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**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: L4-5 Posterior instrumented Fusion Qty 1 is NOT Medically necessary and appropriate.

### **Associated surgical services: Inpatient Hospital Stay Qty 2: 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.

### **Assistant Surgeon Qty 1: 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 services: Lumbar Brace Qty 1:** 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 services: Front Wheeled Walker (indefinite use) Qty 1:** 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 services: 3 in1 Commode (indefinite use) Qty 1:** 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.