

<b>Case Number:</b>	CM15-0102062		
<b>Date Assigned:</b>	06/04/2015	<b>Date of Injury:</b>	06/30/2003
<b>Decision Date:</b>	07/10/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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 44-year-old male, with a reported date of injury of 06/30/2003. The diagnoses include status post L5-S1 posterior spinal fusion with continued bowel dysfunction/incontinence; lumbar radiculopathy; lumbar foraminal stenosis at L5-S1; lumbar pseudoarthrosis; and cauda equine syndrome. Treatments to date have included a bone scan on 02/26/2015; physical therapy; lumbar spinal surgery; an MRI of the lumbar spine; electrodiagnostic studies on 12/17/2014; and oral medications. The follow-up examination report dated 05/07/2015 indicates that the injured worker complained of neck, right arm, back, and bilateral leg pain. He described the back/leg pain ratio as 60% back pain and 40% leg pain. His chief complaint was leg/back pain. An examination of the lumbar spine showed abnormal and limited movement, decreased lumbar range of motion with pain; normal gait; positive sciatic notch tenderness on the left; positive posterior iliac crest tenderness on the left; normal sensation in the back and lower extremities; positive left straight leg raise test; and decreased bilateral hip range of motion without pain. The treating physician requested posterior/anterior/posterior lumbar fusion at L5-S1; five-day inpatient hospital stay; co-surgeon; medical clearance; pre-operative appointment to include a chest x-ray; eighteen (18) post-operative physical therapy sessions; and one Cybertech hard back brace. The surgery was recommended since the injured worker had L5 and S1 radiculopathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) posterior/anterior/posterior lumbar fusion at L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 30. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back, Lumbar & Thoracic (Acute & Chronic); Fusion.

**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. Documentation does not show instability following his prior lumbar surgery. 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. The requested treatment: One (1) posterior/anterior/posterior lumbar fusion at L5-S1 is not medically necessary and appropriate.

**Associated surgical service: 5 days inpatient hospital stay: 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: One (1) 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: One (1) medical clearance to include EKG and Labs (CBC, CMP, TSH, BMP), US and spirometry with an internal medicine specialist: 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: One (1) pre-op appointment to include chest x-rays:** 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: 18 post-op physical therapy sessions:** 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: One (1) Cybertech hard 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.