

<b>Case Number:</b>	CM15-0103566		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	08/28/2002
<b>Decision Date:</b>	07/10/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2015

### 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 37-year-old female, who sustained an industrial injury on 08/28/2002. The injured worker reported lower back pain and right knee pain after a fall. On provider visit dated 04/24/2015 the injured worker has reported low back pain. On examination of the lumbar area was noted to have a well-healed scar. Lumbosacral spine was noted as having a decreased range of motion due to severe low back pain. The diagnoses have included displacement lumbar disk without myelopathy, lumbosacral radiculitis, and back muscle spasms. Treatment to date has medication, laboratory studies and injection on 10/09/2014 left L3-L4 microdiscectomy and hemilaminectomy and status post lumbar anterior/posterior fusion L5-S1. The injured worker was noted to undergo a CT and MRI diagnostic study. The provider requested spinal direct lateral interbody fusion at L3-L4, posterior spinal fusion at L3-S1 with BMP, FRA, and instrumentation, associated surgical service: assistant surgeon, pre-op medical clearance and associated surgical service: inpatient hospital stay x3 days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Spinal Direct Lateral Interbody Fusion at L3-4: 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:** 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. Radiologist's report of MRI scan findings does not corroborate provider's opinion. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. Therefore, the requested treatment is not medically necessary and appropriate.

**Posterior Spinal Fusion at L3-S1 with BMP, FRA, and Instrumentation:** 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:** 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. Radiologist's report of MRI scan findings does not corroborate provider's opinion. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. Therefore, the requested treatment is not medically necessary and appropriate.

**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 Medical Clearanc:** 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: Inpatient Hospital Stay (3-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.