

<b>Case Number:</b>	CM15-0105389		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	05/01/2014
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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 48 year old male sustained an industrial injury to the low back on 5/1/14. Previous treatment included L4-5 and L5-S1 lumbar fusion, physical therapy, injections and medications. In a request for authorization dated 4/21/15, the injured worker complained of continuing debilitating symptoms with low back pain radiating to the right leg. The injured worker was waiting for scheduling of another lumbar injection. The physician noted that magnetic resonance imaging lumbar spine showed severe stenosis at L3-4 and pseudoarthrosis at L4-5 and L5-S1. The injured worker exhibited ongoing weakness in the right tibialis anterior with some leg giving way and quadriceps weakness. Current diagnoses included status post lumbar fusion, pseudoarthrosis, marked worsening of radiating right buttock and leg pain and severe stenosis at L3-4. The treatment plan included ALIF L3-S1, ROH L4-S1, posterior laminectomy, fusion L3-S1 with instrumentation, removal of implants with associated surgical services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ALIF L3-S1, ROH L4-S1, Posterior Laminectomy, Fusion L3-S1 with Instrumentation, Removal of Implants: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-7. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Spinal fusion chapter-Hardware implant removal.

**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 is not supplied to support diagnosis of instability. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. No radiologist's report of loosened or broken hardware is found. ODG guidelines do not recommend routine removal of hardware unless it has been shown to be a source of pain, infection, or broken. This evidence is not found. The requested treatment: ALIF L3-S1, ROH L4-S1, posterior laminectomy, fusion L3-S1 with instrumentation, removal of implants is NOT Medically necessary and appropriate.

**Associated service: 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 service: Assistant:** 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 service: 3 Day Inpatient 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 service: LSO 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.

**Associated service: Bone Stimulator: 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 service: Bone Stimulator Fitting: 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.