

<b>Case Number:</b>	CM15-0018371		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	11/01/2001
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	01/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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: California

Certification(s)/Specialty: Pediatrics, 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 62-year-old male who reported an injury on 11/01/2001 with an unknown mechanism of injury. Current diagnoses include spinal stenosis of the lumbar region and spondylolisthesis. Past treatment includes the use of physical therapy, medications, and epidural steroid injection. Pertinent diagnostic studies included lumbar MRI dated 06/06/2014, which revealed severe degenerative lumbar spondylosis, most notable for severe spinal stenosis at L2-3 and L4-5 and severe neural foraminal narrowing at L4-5 and L5-S1. Other diagnostic studies include EMGs performed on 11/06/2014, which revealed no electrodiagnostic evidence to support radiculopathy, plexopathy, myopathy or peripheral neuropathy. The clinical note dating 01/15/2015 indicates the patient was seen with continued complaints of lower back pain and right radicular pain. Physical examination findings revealed pain with range of motion of the lower back. There was noted to be decreased strength on right dorsiflexion. There was a noted positive right seated straight leg raise. The treatment plan includes a laminectomy of L2-S1, posterior spinal fusion T11-S1, interbody fusion L5-S1 with inpatient stay of 3 days, preoperative medical clearance, preoperative labs including CBC, CMP, PTT, PT/INR, a pre-op urinalysis, a pre-op chest x-ray, a pre-op nares culture for MRSA, pre-op EKG, a surgical assist PA, post-op DME purchase: lumbar brace, and a post-op DME purchase: DJO bone growth stimulator. The lumbar spine surgery with fusion is recommended to correct the patient's lower back pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Laminectomy L2-S1, Posterior Spinal Fusion T11-S1, Interbody Fusion L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th Edition (web) 2015, Low Back chapter, Fusion (spinal).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Fusion (Spinal).

**Decision rationale:** The California ACOEM Guidelines state that a referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanied objective signs of neural compromise, activity limitations due to radiating leg pain for more than 1 month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. More specifically, the Official Disability Guidelines state that spinal fusions may be indicated for patients who have neural arch defect, segmental instability, primary mechanical back pain, and preoperative clinical surgical indications for spinal fusion should include all pain generators are identified and treated and, all physical medicine and manual therapy interventions are completed, and x-rays demonstrating spinal instability and/or myelograms, CT myelogram, or discography and MRIs demonstrating disc pathology correlated with symptoms and exam findings, and spine pathology limited to 2 levels. Given the above, this request is not supported. The clinical documentation submitted for review showed no significant indications of instability of the lumbar spine. In addition, the MRI of the lumbar spine, dating 06/06/2014, failed to show instability at all of the levels requested. Furthermore, a psychosocial screen has not been provided. Given all of the above, the request for a laminectomy L2-S1, posterior spinal fusion T11-S1, interbody fusion L5-S1 is not medically necessary.

**Associated Surgical Service: Inpatient 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.

**Associated Surgical Service: Internist for Pre-Op Medical Clearance: 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-Op Labs: CBC, CMP, PTT, PT/INR:** 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-Op Urinalysis:** 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-Op Chest X-Ray:** 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-Op Nares Culture for MRSA:** 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.

**Post-Op DME Purchase: Lumbar 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.

**Post-Op DME Purchase: DJO Bone Growth 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 Surgical Service: Surgical Assist: PA:** 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-Op EKG:** 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.