

<b>Case Number:</b>	CM15-0138754		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	09/20/1995
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	07/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2015

### 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: Orthopedic 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 70 year old, male who sustained a work related injury on 9-20-95. The diagnoses have included Treatments have included oral medications, physical therapy and lumbar epidural injections. In the Primary Treating Physician's Orthopedic Reevaluation dated 5-28-15, the injured worker reports constant, moderate low back pain with radiating pain down both legs. He rates the back pain level a 6-7.5 out of 10. He reports intermittent, moderate leg pain. He rates this pain level a 6-8 out of 10. On physical examination, he has increased tone and tenderness about the paralumbar muscles with tenderness at the midline thoraco-lumbar junction and over the level of L5-S1 facets and tight greater sciatic notch. He has muscle spasms. Sensation is normal in levels L3-S1. Deep tendon reflexes are 2+. Motor strength bilaterally is 5 out of 5. The EMG-nerve conduction study done on 5-4-15 shows L5 and S1 radiculopathy. MRI of lumbar spine dated 4-10-15 shows an interval decrease of the left paraspinal fluid collection. Interbody fusion at L2-5 and instrumentation and fusion change at L2-4. Grade I retrolisthesis of L2 on L3 and L3 on L4 both measuring 3 mm with bilateral neural foraminal stenosis at L2-3 and L3-4. Bilateral mild foraminal stenosis at L4-5. He is not working. The treatment plan includes requests for lumbar spine surgery, associated treatments and for medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior lumbar interbody fusion L2-3 and L5-S1; hardware screw removal, Gill laminectomy of L2-L3 and L5-S1 with pedicle screw fixation at L2-3, L3-4 and L4-5:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 310. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Fusion.

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm, severe stenosis or psychiatric clearance from the exam note of 5/28/15 to warrant fusion. Therefore the determination is non-certification for lumbar fusion.

**Associated surgical service: X-ray of full length sagittal scoliosis:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office visit.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Assistant surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Centers for Medicare and Medicaid Services.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aaos.org/about/papers/position/1120.asp>.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Vascular 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: Cybertech 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.

**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.

**Associated surgical service: Bone stimulator:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, bone growth stimulator.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Cryotherapy unit x 1 month: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 161.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Continuous flow cryotherapy.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Norco 5/325mg #100: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.