

<b>Case Number:</b>	CM15-0181445		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	03/17/2000
<b>Decision Date:</b>	11/13/2015	<b>UR Denial Date:</b>	09/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2015

### 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, Montana  
 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 61 year old man sustained an industrial injury on 3-17-2000. The mechanism of injury is not detailed. Evaluations include lumbar spine MRIs dated 2-26-2013 and 8-5-2015, left hip CT scan dated 10-15-2014, pelvis MRI dated 10-27-2014, electrodiagnostic studies of the bilateral lower extremities dated 8-18-2014, and lumbar spine CT scan dated 8-5-2015. Treatment has included oral medications and transforaminal epidural steroid injections. Physician notes dated 8- 25-2015 show complaints of lumbosacral pain. Recommendations include surgical intervention.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Extreme Interbody Fusion on L2-3 with Peek cage and Allo/Autograft and Bone Morphogenetic protein:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar and Thoracic Chapter (Online Version).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of significant instability. The California MTUS guidelines recommend lumbar surgery if there are severe persistent, debilitating lower extremity complaints, clear clinical and imaging evidence of a specific lesion corresponding to a nerve root or spinal cord level, corroborated by electrophysiological studies, which is known to respond to surgical repair both in the near and long term. Documentation does not provide this evidence. The requested treatment: Extreme Interbody Fusion on L2-3 with Peek cage and Allo/Autograft and Bone Morphogenetic protein is not medically necessary and appropriate.

**Posterior Spinal Fusion with instrumentation on L2-3 and Bilateral L3-4 posterior microdepression and exploration of fusion mass and removal of hardware and possible L5-S1 rearthrodesis:** 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) Low Back Lumbar and Thoracic Chapter (Online Version).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of significant instability. The California MTUS guidelines recommend lumbar surgery if there are severe persistent, debilitating lower extremity complaints, clear clinical and imaging evidence of a specific lesion corresponding to a nerve root or spinal cord level, corroborated by electrophysiological studies, which is known to respond to surgical repair both in the near and long term. Documentation does not provide this evidence. The requested treatment: Posterior Spinal Fusion with instrumentation on L2-3 and Bilateral L3-4 posterior microdecompression and exploration of fusion mass and removal of hardware and possible L5-S1 rearthrodesis is not medically necessary and appropriate.

**Assistant surgeon:** 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) Low Back Chapter.

**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: medical clearance:** 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) Low Back (Online Version).

**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: lumbar-sacral orthosis brace for purchase:** 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) Low Back Lumbar and Thoracic.

**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: electrical osteogenesis stimulator for purchase:** 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) Low Back Lumbar and Thoracic Chapter (Online Version).

**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: Iceless cold compression device with DVT prophylaxis x 14 days rental:** 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) Low Back Lumbar and Thoracic Chapter (Online Version).

**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.