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| <b>Case Number:</b>   | CM15-0191126 |                              |            |
| <b>Date Assigned:</b> | 10/05/2015   | <b>Date of Injury:</b>       | 07/09/2009 |
| <b>Decision Date:</b> | 11/16/2015   | <b>UR Denial Date:</b>       | 09/16/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/29/2015 |

### 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, Montana, California  
 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 67 year old male, who sustained an industrial injury on 7-9-2009. Medical records indicate the worker is undergoing treatment for failed low back syndrome, lumbar 3 to sacral 1 herniated nucleus pulposus decompression in 2009, anterior lumbar discectomy and fusion in 2010, status post posterior revision in 2011 with nonunion and status post revision in 2013. A recent progress report dated 9-9-2015, reported the injured worker complained of low back pain rated 8 out of 10 and persistent bilateral lower extremity pain and weakness. Physical examination revealed lumbar tenderness, weakness and numbness in the left lower extremity, normal gait and lumbar range of motion decreased about 60%. Treatment to date has included multiple lumbar surgeries, epidural steroid injection, physical therapy and medication management. On 9-10-2015, the Request for Authorization requested Exploration of fusion at lumbar 3-sacral1, revision decompression possible revision fusion with hardware and local and bone allograft and associated services. On 9-16-2015, the Utilization Review noncertified the request for Exploration of fusion at lumbar 3-sacral 1, revision decompression possible revision fusion with hardware and local and bone allograft and associated services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Exploration of fusion at L3-S1, revision decompression possible revision fusion with hardware and local and bone allograft: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back.

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

**Decision rationale:** The California MTUS guidelines recommend lumbar surgery if there is 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 provider argues for an exploration of the lumbar fusion despite the radiographic reports of stable findings over years. The documentation does not contain test results or findings to support reoperation. The requested treatment: Exploration of fusion at L3-S1, revision decompression possible revision fusion with hardware and local and bone allograft 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, Low back.

**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: 23 Hour stay: 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:** 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: C-Arm: 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: Andrews table:** 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: Xenon headlight:** 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: Muscle 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, TENS.

**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: LSO Lumbar brace:** Upheld

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

**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: Hot/Cold therapy unit:** Upheld

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

**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.