

<b>Case Number:</b>	CM15-0218387		
<b>Date Assigned:</b>	11/10/2015	<b>Date of Injury:</b>	10/01/2014
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	11/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2015

### 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(n) 58 year old female, who sustained an industrial injury on 10-1-14. The injured worker was diagnosed as having lumbosacral radiculopathy, left paracentral herniation at L5-S1 and chronic low back pain. Subjective findings (4-30-15, 5-28-15, 6-25-15 and 7-1-15) indicated 8-9 out of 10 low back pain radiating to the bilateral lower extremities with numbness and tingling in both legs. Objective findings (4-30-15, 5-28-15, 6-25-15 and 7-1-15) revealed lumbar flexion is 20 degrees, extension is 0-5 degrees and lateral flexion is 0-5 degrees. There is tenderness to palpation along the lumbar spine and a positive straight leg raise test bilaterally. As of the PR2 dated 9-23-15, the injured worker reports continued back and bilateral leg pain. She has quit smoking and other nicotine products. Objective findings include 0 degrees of lumbar extension due to pain, tenderness to palpation across the low back and a positive straight leg raise test. Treatment to date has included a lumbar CT on 10-7-15 showing grade 1 degenerative anterolisthesis with severe narrowing and vacuum phenomenon, physical therapy for the lumbar spine (number of sessions not provided), Tramadol, Norco, Terocin patch and topical creams. The Utilization Review dated 11-2-15, non-certified the request for a lumbar decompression and instrumented fusion, autograft, allograft, synthetic graft, bone marrow aspiration, iliac crest bone graft L4-5, associated services, pre-op medical clearance, pre-op chest x-ray and pre-op blood work.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lumbar Decompression and Instrumented Fusion, Autograft, Allograft, Synthetic Graft, Bone Marrow Aspiration, Iliac Crest Bone Graft L4-5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Lumbar Spinal Fusion.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Fusion (spinal).

**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 correlating exam at L4/5 from the exam note of 9/23/15 or psychiatric clearance from the exam note of 9/23/15 to warrant fusion. Therefore, the request is not medically necessary for lumbar fusion.

**Assistant 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: 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.

**Associated Surgical Service: Hospital Stay x2-3 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.

**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 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 Blood Work:** 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: Aquatic Physical Therapy x8:** 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: Land Physical Therapy x12:** 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: Trimod:** 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 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.