

<b>Case Number:</b>	CM15-0039685		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	03/03/2009
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	01/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/02/2015

### 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

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 50 year old male, who sustained an industrial injury on March 3, 2009. He reported feeling a pulling sensation in his back while pulling a fiber optic cable through conduit. The injured worker was diagnosed as having depression, facet arthropathy L4-L5 and L5-S1, mild lateral recess stenosis L4-L5, worsening right leg radiculopathy, status post L5-S1 fusion, narcotic tolerance, and posterior pseudarthrosis L5-S1. Treatment to date has included lumbar fusion 2010, removal of hardware 2011, physical therapy, sacroiliac joint blocks, lumbar facet blocks, lumbar spine MRI, and medication. Currently, the injured worker complains of low back pain radiating into the buttocks and hips and down his legs, rating his symptoms a 4-6/10 on the visual analog scale (VAS) with medication and a 7-10/10 on the visual analog scale (VAS) without medication. The Primary Treating Physician's report dated January 19, 2015, noted the injured worker had received diagnostic sacroiliac blocks which were non-diagnostic with very little pain relief, and L5-S1 facet blocks which were diagnostic, decreasing his symptoms from a 6/10 to a 1-2/10 on the visual analog scale (VAS). Current medications were listed as Prilosec, Atenolol, and Norco. Physical examination of the lumbar spine was noted to show the injured worker with a normal gait, and no evidence of tenderness in the paravertebral muscles, sacroiliac joints, sciatic notch, flanks, or over the coccyx. Straight leg raise was noted to be positive on the left and negative on the right. A lumbar spine CT scan dated August 15, 2014, was read as showing a solid fusion at L5-S1 anteriorly, with an incomplete fusion at L5-S1 posteriorly, and disc space narrowing at L4-L5. The Physician noted a request for authorization for a revision posterior fusion at L5-S1 with non-segmental instrumentation, with the additional

associated services including a LSO brace, pneumatic intermittent compression device, bone growth stimulator due to multilevel fusion, post-operative physiotherapy, and pre-operative medical clearance and chest x-ray.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Revision Posterior Fusion at L5-S1 with Non Segmental Instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 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): 305,307.

**Decision rationale:** The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The requested treatment is for a revision of posterior fusion L5-S1. Documentation does not show any abnormal motion at this level. Documentation does not corroborate his physical exam with his imaging studies. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: Revision Posterior Fusion at L5-S1 with Non Segmental Instrumentation Is NOT Medically necessary and appropriate.

#### **Associated surgical service: LSO Brace Purchase: Upheld**

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

**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: Pneumatic Intermittent Compression Device Rental x 30 days: Upheld**

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

**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 Growth Stimulator Purchase:** Upheld

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

**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 Physio Therapy 3x6:** Upheld

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

**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-Operative Medical Clearance:** Upheld

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

**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: Chest X-ray:** Upheld

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

**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.

**Assistant Surgeon:** Upheld

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

**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: 3 day inpatient stay:** Upheld

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

**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: Urine Toxicology Screening:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

**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.