

<b>Case Number:</b>	CM15-0042108		
<b>Date Assigned:</b>	04/10/2015	<b>Date of Injury:</b>	08/14/2007
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	02/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2015

### 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: 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:

This 62 year old male miss-stepped on August 14, 2007 falling backwards onto his back. The diagnoses have included lumbar pain, multilevel lumbar stenosis, lumbar radiculitis, lumbar facet syndrome with a large lumbar four-lumbar five facet cyst, lumbar five sacral one paracentral annular tear with severe bilateral foraminal narrowing and long term opioid analgesic therapy. Treatment to date has included medications, radiological studies and electro diagnostic studies. Most current documentation dated May 15, 2014 notes that the injured worker reported continued low back pain with radiation to the lower extremities with associated weakness, numbness and tingling. Physical examination of the lumbar spine revealed tenderness of the paraspinal areas and a painful and limited range of motion. A straight leg raise test was negative bilaterally. The treating physician noted that given the injured workers ongoing symptoms and the progressive nature of his neurologic dysfunction, surgical treatment was recommended. The treating physician's plan of care included a request for a posterior lumbar decompression and fusion of L4-5 and L5-S1, possible L3-4 with pedicle screw fixation mentation to include allograft, autograft, application of a biomechanical device, bone marrow aspiration and fluoroscopy, medical and cardiac clearance, external bone growth stimulator and post-operative lumbar sacral brace.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Posterior lumbar decompression and fusion L4-5 and L5-S1, possible L3-4 with pedicle screw fixation mentation to include allograft, autograft, app biomech device, bone marrow aspiration and fluoroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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 California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower leg symptoms. The documentation shows this patient has been complaining of low back pain. Documentation does not disclose disabling lower extremity symptoms. 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 lumbar decompression and fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. Therefore, the request for posterior lumbar decompression and fusion L4-5 and L5-S1, possible L3-4 with pedicle screw fixation mentation to include allograft, autograft, app biomech device, bone marrow aspiration and fluoroscopy is not medically necessary and appropriate.

**Medical and cardiac 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.

**External bone growth 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.

**Post op lumbar sacral 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.