

<b>Case Number:</b>	CM15-0045289		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	05/07/1996
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2015

### 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 47 year old female, who sustained an industrial injury on May 7, 1996. She reported low back pain. The injured worker was diagnosed as having lumbar 3-4 transitional spondylosis with spinal stenosis and neurogenic claudication, status post global decompression, fusion and instrumentation of the lumbar 4-5 and lumbar 5 through sacral 1 levels and status post insertion of a morphine intrathecal pump. Treatment to date has included radiographic imaging, diagnostic studies, surgical interventions of the lumbar spine, trigger point injections, pain pump placement, pain medications and work restrictions. Currently, the injured worker complains of low back pain and left leg pain. The injured worker reported an industrial injury in 1996, resulting in chronic low back and left lower extremity pain. She was treated conservatively with medications and surgically three times without resolution of the pain. She has also been treated with trigger point injections and had a pain pump placed. Evaluation on February 5, 2015, revealed continued pain. Additional surgical intervention was recommended.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar extreme lateral L3-L4 interbody fusion with peek spacer filled with bone morphogenic protein:** 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 chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305 and 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. While lateral transitional spondylosis at L3-4 is described, evidence is not provided of instability. 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. The lumbar spine scans show only mild canal and foraminal narrowing. Documentation does not show progression. The requested treatment is for an extreme lateral interbody fusion is not recommended by the ODG guidelines. The MTUS guidelines note that the efficacy of fusion without instability has not been demonstrated. The requested treatment: Lumbar extreme lateral (L3/L4) interbody fusion with peek spacer filled with bone morphogenic protein Is NOT Medically necessary and appropriate.

**Posterior Lumbar (L3-L4) laminectomy & posterior segmental fixation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-306.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305 and 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. While lateral transitional spondylosis at L3-4 is described, evidence is not provided of instability. 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: Posterior Lumbar (L3-L4) laminectomy & posterior segmental fixation is NOT Medically necessary and appropriate.

**Inpatient stay, hospital, 4 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.

**Medical clearance, Cardiologist:** 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-operative CT (computed tomography) Scan: Lumbar L1-L4:** 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.

**DME (durable medical equipment) Walker with front wheels:** 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.

**DME (durable medical equipment) Raised Toilet Seat:** 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.

**DME (durable medical equipment) Grabber:** 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.