

<b>Case Number:</b>	CM15-0052054		
<b>Date Assigned:</b>	04/16/2015	<b>Date of Injury:</b>	08/26/1999
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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 71 year old female who sustained an industrial injury on 08/26/99. Initial complaints and diagnoses are not available. Treatments to date include a cervical laminectomy. Diagnostic studies include a MRI of the cervical spine and lumbar spine, and x-rays of the lumbar spine. Current complaints include bilateral lower extremity radicular symptoms. Current diagnoses include lumbar and cervical disc degeneration and spinal stenosis. In a progress note dated 02/11/15 the treating provider reports the plan of care as a lumbar laminectomy with fusion. The requested treatments are a lumbar laminectomy, arthrodesis, and associated services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthrodesis, posterior interbody decompression, laminectomy L3-4 & L4-5; posterior segmental instrumentation L3-4 & L4-5 QTY 1; fusion with grafting at two levels (Allograft) L3-4 & L4-5 QTY 2 with surgical assistant: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 306, 307 and 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Lumbar

Chapter: Discectomy/laminectomy, ODG TWC 2014; Low Back, Lumbar & Thoracic Chapter (Acute & Chronic).

**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 provider states there has been movement at L4-5 but no radiology reports are found in the documentation showing any change in the grade I spondylolistheis of 8 mm. The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling shoulder and arm symptoms. The documentation shows this patient has been complaining of pain in the neck, knee where she had had a replacement and her back. Documentation does not disclose objective neurological progression. No measurements disclosing atrophy are found. 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 patient's EMGs of both upper and lower extremities on 10/01/2004 were normal. Documentation does not show evidence correlating her exam with her tests. The requested treatment is for an arthrodesis, posterior interbody, and decompression, laminectomy L3-4, L4-5. The CT scan only showed moderate stenosis at L3-4. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: Arthrodesis, posterior interbody decompression, laminectomy L3-4 & L4-5; posterior segmental instrumentation L3-4 & L4-5 QTY 1; fusion with grafting at two levels (Allograft) L3-4 & L4-5 QTY 2 with surgical assistant is not medically necessary and appropriate.

**Post-op LSO Brace QTY 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back - lumbar & Thoracic (Acute & Chronic) Chapter.

**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 QTY 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back- Lumbar & Thoracic (Acute & Chronic) Chapter.

**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 Labs: CBC, Basic Metabolic Panel, PT, PTT and ECG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI).

**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 PA and lateral:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI).

**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.

**3 night 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 (ODG); Low Back- Lumbar & Thoracic (Acute & Chronic) Chapter.

**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.