

<b>Case Number:</b>	CM15-0081001		
<b>Date Assigned:</b>	05/01/2015	<b>Date of Injury:</b>	09/03/1973
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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 64 year old male, who sustained an industrial injury on 9/3/73. Initial complaints are not noted. The injured worker was diagnosed as having lumbar discopathy, internal derangement bilateral knees; residuals related to cervical reconstruction; bilateral carpal tunnel release; right knee surgery x3 with advanced degenerative joint disease; double crush injury lumbar discopathy; internal derangement bilateral knees. Treatment to date has included status post cervical reconstruction with hybrid construction; status post bilateral carpal tunnel release; bilateral C4-5 and C5-6 facet injections (9/1/11). Diagnostics included MRI lumbar spine 8/18/14); EMG/NCV bilateral upper and lower extremities (8/7/13); MRI right wrist (6/18/10). Currently, the PR-2 notes dated 2/26/15 indicated the injured worker complains of persistent and deteriorating symptoms in the low back and lower extremities. The injured worker has had chronic pain for 2 years without improvement and wishes to proceed with surgery as quality of life has been severely limited. The pain is constant and severe low back pain and aggravated by activity. The pain is described as sharp, stabbing, with radiation into the right lower extremity with burning and weakness noted. The pain level is 9/10 and is experiencing difficulty sleeping due to pain. He also complains of intermittent cervical spine pain radiating to his upper extremities associated with migrainous headaches, intermittent pain in the bilateral elbows and wrists and bilateral knee pain 4/10. There is a complete physical examination and the provider reviewed x-rays and a lumbar spine MRI (8/18/14) that confirms significant disc pathology at L4-L5 and L5-S1 with compromise on the existing nerve roots and asymmetric disc herniation. A discogram performed 2015 notes to be positive at L5. The provider's treatment

plan includes the requested: L4-S1 posterior lumbar interbody fusion (PLIF) with instrumentation and possible reduction of listhesis as well as addressing functional level pathology if present, and bilateral facetectomies; 3 day in patient hospital stay; assistant surgeon; medical clearance; 1 front wheel walker; 1 ice unit; 1 bone stimulator; 1 TLSO brace; 3 in 1 commode.

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

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

**L4-S1 posterior lumbar interbody fusion (PLIF) with instrumentation and possible reduction of listhesis as well as addressing functional level pathology if present, and bilatearl facetectomies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (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. Documentation does not show pathological instability. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. No such evidence is presented. The guidelines note the patient would have failed a trial of conservative therapy. No details are provided regarding filed conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: L4-S1 posterior lumbar interbody fusion (PLIF) with instrumentation and possible reduction of listhesis as well as addressing functional level pathology if present, and bilateral facetectomies is NOT Medically necessary and appropriate.

**Associated surgical services: 3 day in patient hospital 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).

**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 services: 1 assistant surgeon:** 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).

**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: Medical clearance with internist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information & Ground Rules, California Official Medical Fee Schedule, 1999, pages 92-93.

**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: 1 front wheel walker:** 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) Knee & Leg (Acute & Chronic).

**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: 1 ice unit:** 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: 1 bone stimulator:** 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).

**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: 1 TLSO brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic).

**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 in 1 commode:** 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) Knee & Leg (Acute & Chronic).

**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.