

<b>Case Number:</b>	CM15-0086128		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	08/22/2012
<b>Decision Date:</b>	06/19/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2015

### 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:

The injured worker is a 50 year old female, who sustained an industrial injury on August 22, 2012. She reported sharp lower back pain radiating into her left lower extremity. The injured worker was diagnosed as having spinal stenosis and instability at lumbar 4-lumbar 5 and lumbar 5-sacral 1, early degeneration of lumbar 2-lumbar 3 and lumbar 3-lumbar 4, grade I to II spondylolisthesis at lumbar 4-lumbar 5, and status post decompression Coflex. Diagnostic studies to date have included MRIs and x-rays. Treatment to date has included physical therapy, work modifications, a facet block injection, and medications including pain, anti-epilepsy, and non-steroidal anti-inflammatory. On March 20, 2015, the injured worker complains of constant low back pain radiating to the bilateral lower extremities. Her pain is rated 5/10. Prolonged activities increase her pain. She is currently working. The physical exam revealed tenderness to palpation over the lumbar paraspinal musculature, decreased range of motion, decreased a positive straight leg raise test, and sacroiliac junction pain. The requested treatments include an anterior-posterior combined decompression and fusion at lumbar 4-lumbar 5 and lumbar 5-sacral 1 with removal of hardware (Coflex); assistant surgeon, 2 nights inpatient stay, Internal Medicine clearance, post-op physical therapy for the lumbar spine x 24 visits; a front wheeled walker, a 3 in 1 commode, a hospital bed rental x 30 days, an electrical bone growth stimulator for the lumbar spine x 6 to 9 months, transportation to and from the facility, and Voltaren XR (diclofenac ER).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior-posterior combined decompression and fusion at L4-L5 and L5-S1 with removal of hardware (Coflex): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 306-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Spinal fusion chapter-Hardware removal.

**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 note that the efficacy of fusion in the absence of instability has not been proven. The ODG guidelines do not recommend hardware removal unless it is broken, infected or found to be the cause of persistent pain. Documentation does not support this. Mention is made that the hardware is meandering but no radiologist's report is found to substantiate this comment. The requested treatment: Anterior -posterior combined decompression and fusion at L4-L5 and L5-S1 with removal of hardware (Coflex) is NOT Medically necessary and appropriate.

**Internal medicine 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.

**Twenty four post-op physical therapy visits for the lumbar spine:** 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: Front wheeled walker:** 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: 3 in 1 commode:** 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: Thirty day hospital bed rental:** 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: Electrical bone growth stimulator for 6 to 9 months for the lumbar spine:** 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.

**Transportation to and from the facility:** 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.

**Voltaren XR (Diclofenac ER) 100mg #30, one by mouth once a day:** 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.