

<b>Case Number:</b>	CM15-0089834		
<b>Date Assigned:</b>	05/15/2015	<b>Date of Injury:</b>	03/04/2014
<b>Decision Date:</b>	06/15/2015	<b>UR Denial Date:</b>	05/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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 56-year-old male, who sustained an industrial injury on 3/4/14. He reported initial complaints of right shoulder, lower back, right wrist and elbow. The injured worker was diagnosed as having thoracic /lumbosacral neuritis or radiculitis; lumbar spinal stenosis. Treatment to date has included multiple surgeries. Diagnostics included MRI lumbar spine (5/29/13 and 9/30/14)); CT scan lumbar spine (10/9/14); X-rays lumbar spine (4/22/15). Currently, the PR-2 notes dated 4/22/15 indicated the injured worker is a status post L5-S1 decompression and instrumented fusion followed by a removal of hardware from 15 years ago. He returns to the office after 15 years stating the surgery did well, however recently he has increased pain in his lower back that is radiating to the bilateral legs with tingling and numbness to both legs with some difficulty walking. He has not had any recent conservative management and is not interested in injections. His current work involves a lot of walking, pushing and pulling and does not feel he can return to work at his current state. He has not problems with using his hands although he does have pain in his right shoulder, right elbow and right wrist. His past surgical history is significant for the L5-S1 decompression/instrumentation/fusion followed by removal of the hardware, a gastric bypass, right distal clavicle resection and most recently a carpal tunnel/ right cubital tunnel release in 2014. Review of the diagnostic studies includes x- ray of cervical and lumbar spine and MRI of the lumbar spine with impression of moderate to severe foraminal stenosis at L3-L4 and L4-L5. The provider is requesting: Decompression at L3- 4 & L4-5, Fusion at L4-5; inpatient hospital stay x 2 days; preoperative medical clearance; pre-operative chest x-ray and EKG; Pre-op labs: CMP, PT, PTT, INR, CBC with differential, Urinalysis, HgB A1C; lumbar brace and bone growth stimulator.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Decompression at L3-4 & L4-5: 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 recommend cervical 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. Documentation does not show this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. Therefore, the requested treatment is not medically necessary and appropriate.

### **Fusion at L4-5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**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 guidelines note that the efficacy of fusion in the absence of instability has not been proven. Therefore, the requested treatment is not medically necessary and appropriate.

### **Inpatient Hospital Stay (2-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.

**Pre-Operative Medical 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.

**Pre-Operative Chest X-Ray: 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 Labs: CMP, PT, PTT, INR, CBC with differential, Urinalysis, HgB A1C: 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 EKG: 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: Lumbar 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.

**Associated Surgical Service: 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.