

<b>Case Number:</b>	CM15-0016650		
<b>Date Assigned:</b>	02/05/2015	<b>Date of Injury:</b>	09/12/2012
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/29/2015

### 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: California  
Certification(s)/Specialty: Orthopedic 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 male, who sustained an industrial injury on 09/12/2012. On provider visit dated 11/25/2014 the injured worker has reported chronic pain in lower back that extends to the left hip and left knee region. On examination he was noted to have a decreased range of motion of the lumbar spine secondary to pain and lumbar tenderness and paraspinous muscle spasming. The diagnoses have included lumbar spine disease and spondylosis with right lower extremity weakness. Treatment to date has included medication. Treatment plan included Anterior and Posterior Lumbar Fusion and Decompression at Level L3-4, bone stimulator and back brace. On 01/19/2015 Utilization Review non-certified Anterior and Posterior Lumbar Fusion and Decompression at Level L3-4, bone stimulator and back brace. The CA MTUS ACOEM Guidelines and ODG were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior and Posterior Lumbar Fusion and Decompression at Level L3-4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back, Fusion

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm, severe stenosis or psychiatric clearance from the exam note of 11/25/14 to warrant fusion. Therefore the determination is non-certification for lumbar fusion.

**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)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline, Low Back, Bone growth stimulator

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Back Brace:** 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:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.