

<b>Case Number:</b>	CM15-0173431		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	01/10/2011
<b>Decision Date:</b>	11/03/2015	<b>UR Denial Date:</b>	08/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/02/2015

### 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, Montana

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 (IW) is a 52 year old male who sustained an industrial injury on 01/10/2011. Medical records indicate the worker was being treated for lumbar radiculopathy, lumbar stenosis, and degenerative disc disease. Treatment to date included a L3-4 laminotomy decompression in 2011 which helped, but did not eradicate all symptoms. Provider notes of 06-16-2015 stated he feels his pain has "recurred and worsened". His pain is currently in a similar distribution as it was pre-surgery. It is notably worse in the mid to upper spine area. He has decreased sensation in the L3-4 distribution on the left. He has had physical therapy and medical pain management, and injections. Current medications include Tylenol, Naproxen, Fetzima, Norco, and Lidocaine 5% patch. According to the 06-16-2015 provider notes, he has had multiple radiographic exams and MRI's. These demonstrate disc degeneration at L3-4, bulging neural foraminal stenosis and far lateral disc herniation. There is evidence of scarring and prior surgery at the left L3-4 level and there is a persistence of the far lateral disc bulge and persistent stenosis. There are more advanced degenerative disc changes at L3-L4. His thoracolumbar spine range of motion flexion 70, extension 40, and lateral bending 30. Straight leg raise is positive on the left. The assessment is recurrent lumbar radiculopathy, worsening back pain in the setting of stenosis, disc herniation, and degenerative disc disease. Options were discussed with the worker, and surgical intervention was felt to be indicated. A request for authorization was submitted for: 1. Lateral interbody fusion L3-4; 2. Associated surgical service: 2 day inpatient stay; 3. Pre-op chest X-ray; 4. Pre-op lab, CBC (complete blood count); 5. Pre-op lab, basic metabolic panel (BMP); 6. Pre-op labs: prothrombin time (PT) and partial thromboplastin time (PTT); 7. Pre- op lab, urinalysis (UA)A utilization review decision 08-28-2015 non-approved the request in its entirety.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lateral interbody fusion L3-4:** 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), Treatment Index, 13th Edition (web) 2015, Low Back.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The California MTUS guidelines do recommend spinal fusion for fracture, dislocation and significant instability. The documentation does not show the presence of these. The California MTUS guidelines recommend lumbar surgery if there is severe persistent, debilitating lower extremity complaints, clear clinical and imaging evidence of a specific lesion corresponding to a nerve root or spinal cord level, corroborated by electrophysiological studies which is known to respond to surgical repair both in the near and long term. Documentation does not provide this evidence. The requested Treatment: Lateral interbody fusion L3-4 is not medically necessary and appropriate.

### **Associated surgical service: 2 day inpatient 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), Treatment Index, 13th Edition (web) 2015, Low Back (updated 07-17-2015), Hospital length of stay (LOS).

**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:** 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), Treatment Index, 13th Edition (web) 2015, Low Back..

**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 lab, CBC (complete blood count): 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), Treatment Index, 13th Edition (web) 2015, Low Back (updated 07/17/2015), Preoperative lab testing.

**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 lab, basic metabolic panel (BMP): 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), Treatment Index, 13th Edition (web) 2015, Low Back, (updated 07/17/2015), Preoperative lab testing.

**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: prothrombin time (PT) and partial thromboplastin time (PTT): 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), Treatment Index, 13th Edition (web) 2015, Low Back, (updated 07/17/2015), Preoperative lab testing.

**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 lab, urinalysis (UA): 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), Treatment Index, 13th Edition (web) 2015, Low Back, (updated 07/17/2015), Preoperative lab testing.

**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.

