

<b>Case Number:</b>	CM15-0095769		
<b>Date Assigned:</b>	05/26/2015	<b>Date of Injury:</b>	10/26/1972
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	04/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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 62 year old male, who sustained an industrial injury on October 26, 1972, incurring low back injuries. Treatment included multiple surgical interventions, epidural steroid injection, chiropractic sessions, Radiofrequency Ablation, medication management and work restrictions. He was diagnosed with lumbar degenerative disc disease, foraminal stenosis, and spinal stenosis. In 2009, a computed tomography revealed multi-level severe degenerative disk disease and advanced facet hypertrophy and high grade spinal stenosis. In 2011, lumbar Magnetic Resonance Imaging revealed unchanged multilevel degenerative disc disease with spinal stenosis. In 2013, the injured worker continued to have severe pain. Treatment included epidural steroid injection. Currently, in 2015, the injured worker complained of chronic, persistent low back pain radiating into the right lower extremity. Magnetic Resonance Imaging revealed levo-scoliosis with degenerative disc disease and extensive postoperative changes and spinal canal stenosis. The treatment plan that was requested for authorization included anterior fusion with discectomy and lumbar laminectomy, inpatient hospital stay for anterior fusion for four days, assistant surgeon, bilateral lumbar posterior fusion and laminectomy, bilateral lumbar revision laminectomy, inpatient hospital stay for posterior fusion for four days, assistant surgeon for posterior fusion, pre-operative clearance and a post-operative purchase of a brace.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Surgery Part 1: Staged anterior fusion with discectomy and L2-3 laminectomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** 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. Documentation does not provide this evidence. The provider opines the novel idea presence of gas within the disc space is evidence of instability without citation of expert opinion to support this contention. 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. 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. No evidence of pathologic movement is provided. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested Treatment: Staged anterior fusion with discectomy and L2-3 laminectomy is NOT Medically necessary and appropriate.

**Associated surgical service: Inpatient hospital stay for anterior fusion x 4 days for stage 1: 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: Assistant surgeon for anterior case: 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.

**Staged Surgery Part 2: Bilateral L2-3 posterior fusion and laminectomy; bilateral L4-5 revision laminectomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308.

**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. 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. Such evidence is not provided. 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. The requested treatment: Bilateral L2-3 posterior fusion and laminectomy; bilateral L4-5 revision laminectomy is NOT Medically necessary and appropriate.

**Associated surgical service: Inpatient x4 days for Staged Surgery Part 2: Bilateral L2-3 Posterior fusion & Laminectomy; Bilat L4-5 revision Laminectomy: 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: Assistant surgeon for Staged Surgery Part 2: 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-op 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.

**Post-op purchase of 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.