

<b>Case Number:</b>	CM13-0013001		
<b>Date Assigned:</b>	02/14/2014	<b>Date of Injury:</b>	05/28/2011
<b>Decision Date:</b>	05/27/2014	<b>UR Denial Date:</b>	07/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant is a 31-year-old female who was injured in a work related accident on May 28, 2011. This was an acute low back complaint while pushing shopping carts. Current records indicate a course of conservative care that has failed. Recent report of November 11, 2013 indicated subjective complaints of continued pain about the low back and legs. It states that previous request had been for an L4-5 and L5 decompression and fusion. Objectively there was noted to be restricted range of motion with positive straight leg raising, hypesthesias to the right L5 dermatomal distribution. Formal imaging includes plain film radiographs from August 1, 2013 that demonstrated transitional vertebrae but no indication of flexion or extension instability. Previous MRI from January 25, 2012 showed disc protrusion at L4-5 with no nerve root compression as well as disc protrusion at L5-S1 with no nerve root compression noted. Further MRI scans or electrodiagnostic studies are not noted. As stated, there is a two level surgical request in the form of L4-5 and L5-S1 fusion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 ANTERIOR, POSTERIOR DISCECTOMY, DECOMPRESSION AND FUSION WITH INSTRUMENTATION AT L4-L5, L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

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

**Decision rationale:** California ACOEM Guidelines do not support the role of a two level fusion. CA MTUS states, "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. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on." Current clinical records fail to demonstrate compressive pathology at the L4-5 or L5-S1 level with no documentation of segmental instability. Absence of the above would fail to support surgical process.

**UNSPECIFIED 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)- HOSPITAL LENGTH OF STAY (LOS) LUMBAR FUSION.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) OFFICIAL DISABILITY GUIDELINES TREATMENT IN WORKER'S COMP , 18TH EDITION, 2013 UPDATES: LOW BACK PROCEDURE - FUSION (SPINAL) FOR AVERAGE HOSPITAL LOS AFTER CRITERIA ARE MET, SEE HOSPITAL LENGTH OF STAY (LOS).

**Decision rationale:** California MTUS Guidelines are silent. When looking at Official Disability criteria, an inpatient stay would not be indicated as need for operative intervention would not be established.

**POST-OPERATIVE PHYSICAL THERAPY VISITS 3 TIMES A WEEK FOR 4 WEEKS, QTY: 12:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** California MTUS Postsurgical Rehabilitative Guidelines would not support twelve sessions of physical therapy as the need for operative intervention has not been established.

**BONE GROWTH 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- CRITERIA FOR THE USE OF INVASIVE OR NON-INVASIVE ELECTRICAL BONE GROWTH STIMULATORS.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) OFFICIAL DISABILITY GUIDELINES TREATMENT IN WORKER'S COMP , 18TH EDITION, 2013 UPDATES: LOW BACK PROCEDURE - BONE GROWTH STIMULATORS (BGS).

**Decision rationale:** California MTUS Guidelines are silent. When looking at Official Disability Guideline criteria, a bone growth stimulator would not be indicated as the need for operative intervention has not been established.

**LSO 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)- LOW BACK CHAPTER: POST OPERATIVE BACK BRACE.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 9, 298, 301.

**Decision rationale:** California MTUS Guidelines would not support a back brace as the need for operative intervention has not been established.

**COLD THERAPY UNIT WITH PAD FOR RENTAL FOR 14 DAYS:** 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)- HEAT/COLD PACKS.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-339.

**Decision rationale:** California ACOEM Guidelines would not support a cryotherapy device for fourteen days as need for operative intervention has not been established.