

<b>Case Number:</b>	CM13-0019418		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	03/30/2010
<b>Decision Date:</b>	02/03/2014	<b>UR Denial Date:</b>	08/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/03/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California, New Jersey and Pennsylvania. 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 physician 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 injured his low back in a work related accident on 03/30/10. Records for review include an orthopedic surgical progress report with [REDACTED] of 07/24/13 indicating ongoing complaints of low back pain. Present complaints are that of excruciating pain to the low back with left radiating pain to the buttock and lateral thigh. It is worse with activities. Physical examination findings showed restricted lumbar range of motion with pain, a normal gait pattern, 5/5 motor tone, +2 equal and symmetrical reflexes, and normal sensation to the bilateral lower extremities. There was a diagnosis of lumbar strain with degenerative disc disease at L5-S1 with central disc protrusion. Based on failed conservative care, a L5-S1 lumbar interbody fusion with cage placement was recommended for further definitive management. Prior lumbar imaging is only documented from February 2011, an MRI report showing diminished disc height at L5-S1 with annular tearing and a 3 to 4 mm disc protrusion, right greater than left. Further clinical imaging is not documented.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ALIF L5-S1 (Anterior Lumbar Interbody Fusion) with Interbody Fusion Cage and Anterior Instrumentation Combined with Percutaneous Pedicle Screw Instrumentation/Posterior Spinal Fusion: Upheld**

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

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

**Decision rationale:** Based on California ACOEM Guidelines, lumbar fusion procedure would not be indicated. Guideline criteria indicate that a lumbar fusion is appropriate in the setting of "spinal fracture, dislocation, spondylolisthesis, instability or motion in a segment operated on". Records for review fail to indicate any evidence of segmental instability or progressive neurologic dysfunction for which the requested lumbar procedure would be warranted. The claimant's last assessment demonstrated no evidence of motor sensory reflexive changes to the lower extremities. The role of surgical process in this chronic stage in the clinical course of care with the claimant's current clinical presentation would not be indicated.

**3 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) Low Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**Decision rationale:** California ACOEM Guidelines are silent. When looking at Official Disability Guidelines, a three day inpatient hospital stay would not be warranted. The nature of surgical intervention has not yet been established. Thus, this would negate the need for postoperative inpatient stay.

**pre-op medical clearance to include Labs; CBC, Chem Panel, PT, PTT, UA, EKG. Blood T&C (2 Units):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 127.

**Decision rationale:** California ACOEM and MTUS Guidelines are silent. When looking at Official Disability Guidelines, preoperative medical testing would also not be indicated. The role of operative intervention in this case has not yet been established. This would negate the need for preoperative medical assessment at present.

**Cybertech Back Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** Based on California MTUS Guidelines, a back brace would not be indicated. The role of a back brace in this case is being requested for postsurgical intervention in the form of fusion. Records do not support the need for operative intervention. Thus, the need of this postoperative DME device would not be indicated.

**cold therapy unit:** 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 Guidelines (ODG).

**Decision rationale:** California MTUS Guidelines are silent. When looking at Official Disability Guidelines criteria, cryotherapy devices are not specifically recommended following lumbar procedures. The surgical process in question in this case has not yet been supported. The role of a postoperative cryotherapy device for the lumbar spine would not be indicated.