

<b>Case Number:</b>	CM13-0029127		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	05/23/2008
<b>Decision Date:</b>	01/21/2014	<b>UR Denial Date:</b>	09/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2013

### 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, has a subspecialty in Fellowship trained in Spine 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 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 patient is a 55-year-old female who reported an injury on 05/23/2008. The patient is noted to have undergone a carpal tunnel release in 02/2008 and to have undergone a repeat right carpal tunnel release, right cubital tunnel release, and a right De Quervain's surgery in 08/2012. The patient underwent a left knee arthroscopic surgery in 06/2012. The patient is noted to have undergone a partial mastectomy in 2012 due to breast cancer. She is noted to have undergone an MRI of the lumbar spine without contrast on 02/04/2013, which reported degenerative changes at L4-5 and L5-S1 with a broad based posterior protrusion at the L5-S1 level causing moderate to severe neural foraminal narrowing on the left and moderate neural foraminal narrowing on the right with encroachment of both exiting nerve roots, and a concentric disc bulge with fissuring of the left posterior portion of the annulus at L4-5. She is reported to complain of ongoing low back pain with radiation of pain to the left greater than right lower extremity with intermittent weakness and numbness of the lower extremity. She is reported to have had undergone an electrodiagnostic study of the bilateral lower extremities on 02/05/2013, which reported an abnormal NCS study with unobtainable bilateral H waves which was felt to be a non-specific finding and could be due to metabolic disorder such as diabetes versus a previous back injury versus S1 radiculopathy. The patient is noted to have a normal EMG of the lower extremities. A clinical note signed by the patient's treating physician, [REDACTED], reported the patient had been referred for a neurosurgery consult for her ongoing low back pain. On physical exam, she is noted to have decreased sensation to light touch and pinprick over the left foot, especially in the second toe and the adjoining area of the big toe and little toes mostly on top of the foot in the L5 distribution. She is reported to have decreased active range of motion in all planes of th

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **L4-S1 transforaminal lumbar interbody fusion (TLIF) and posterior spinal fusion (PSF)/PSI: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Chapter, Fusion (spinal)

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

**Decision rationale:** The patient is reported to complain of ongoing low back pain with radiation of pain to the bilateral lower extremities worse on the left than on the right. She is noted to have undergone conservative treatment including epidural steroid injections on unstated dates with short-term temporary relief of pain. She is noted on MRI to have a broad based posterior disc protrusion at the L5-S1 level, causing moderate to severe left neural foraminal narrowing and moderate right neural foraminal narrowing with encroachment of both exiting nerve roots and a concentric bulge with fissuring at the left posterior portion of the annulus at L4-5. She is noted to have undergone electrodiagnostic studies that noted the absence of the H-reflex on the bilateral lower extremities, which was reported to be a non-specific finding, and normal EMG studies. On physical exam, the patient is noted to have decreased range of motion of the lumbar spine in all planes, positive straight leg raise on the left and decreased sensation to light touch and pinprick over the bilateral lower extremities radiating up into most of her legs including the anterior thigh. The MTUS/ACOEM Guidelines recommend a lumbar decompression for findings of severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies with objective findings of neural compromise and recommend a lumbar fusion for patients who have increased spinal instability after a surgical decompression at the level of degenerative spondylosis. Although the patient is noted to have endplate degenerative changes at the L4-5 with a concentric disc bulge and disc desiccation and mild loss of disc height at L5-S1, the patient's physical exam findings do not correlate with the imaging, there is no documentation of spinal instability and there is no documentation of a pre-surgical psychological evaluation with confounding issues addressed. As such, the requested surgery does not meet Guideline recommendations. Based on the above, the request for an L4-S1 transforaminal lumbar interbody fusion (TLIF) and posterior spinal fusion (PSF)/PSI is non-certified.

**Surgical assistant:** 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.

**Two (2) day inpatient stay: 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.

**Purchase of a lumbar back 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.

**Purchase of an external bone growth stimulator: 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.

**Purchase of one (1) box of four by ten (4x10) Island bandage: 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.

**Postoperative physical therapy three (3) times a week for six (6) weeks: 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.