

<b>Case Number:</b>	CM13-0029734		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	10/06/2010
<b>Decision Date:</b>	04/22/2014	<b>UR Denial Date:</b>	09/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/27/2013

### 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 Texas. 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 patient is a 66-year-old male who reported an injury on 10/06/2010. The mechanism of injury was not stated. The patient is diagnosed with L5-S1 disc herniation, L5-S1 disc stenosis, L5-S1 degenerative disc disease, right greater than left lumbar radiculopathy, and lumbar stenosis at L4-5. The patient was seen by [REDACTED] on 08/28/2013. The patient reported bilateral lower extremity pain. Physical examination revealed slightly decreased sensation along the lateral foot and dorsal foot on the right side, absent reflexes at bilateral knees and ankles, positive straight leg raising on the right, and 5/5 motor strength. Treatment recommendations at that time included an L5-S1 translumbar interbody fusion with a 2-night hospital stay as well as DME, preoperative clearance, and postoperative physical therapy. It was noted that the patient underwent an electrodiagnostic study on 06/28/2013, which revealed evidence consistent with an abnormality involving bilateral fifth lumbar nerve roots.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **INPATIENT RIGHT L5-S1 MINIMALLY INVASIVE TRANSLUMBAR INTERBODY FUSION (MIS TLIF): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary, (updated 5/10/2013)

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

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, extreme progression of symptoms, clear clinical, imaging and electrophysiological evidence of a lesion, and failure of conservative treatment. As per the documentation submitted, the patient does demonstrate decreased sensation, absent reflexes, and positive straight leg raising on the right. However, there is no documentation of an exhaustion of conservative treatment. There is also no evidence of documented instability on flexion and extension view radiographs. Based on the clinical information received, the patient does not currently meet criteria for the requested procedure. As such, the request is non-certified.

**PURCHASE OF LUMBOSACRAL ORTHOSIS (LSO) - 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:** As the patient's surgical procedure has not been authorized, the current request is also not medically necessary. Therefore, the request is non-certified.

**OUTPATIENT POST OPERATIVE PHYSICAL THERAPY TO THE LUMBAR (3 TIMES PER WEEK FOR 4 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:** As the patient's surgical procedure has not been authorized, the current request is also not medically necessary. Therefore, the request is non-certified.

**INPATIENT STAY FOR 2 NIGHTS:** 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:** As the patient's surgical procedure has not been authorized, the current request is also not medically necessary. Therefore, the request is non-certified.