

<b>Case Number:</b>	CM13-0034225		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	06/28/2011
<b>Decision Date:</b>	03/10/2014	<b>UR Denial Date:</b>	09/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/11/2013

### 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. 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:

This is a 55-year-old male who sustained an injury to the low back in a work-related accident on 6/28/11. The clinical records for review documented a course of failed conservative care. Surgery in the form of an L3-4 and L4-5 anterior interbody fusion with iliac crest grafting, a surgical assistant, three day inpatient hospital stay, post-operative physical therapy, and cryotherapy device were recommended. There was no documentation to indicate that the surgical process has been supported by the carrier. At present there is a surgical request for a three level lumbar fusion from L3-4 through L5-S1 to be performed both anteriorly and posteriorly. Prior records do document that imaging included radiographs with degenerative disc disease at L4-5 and L5-S1 from 2012 and MRI scan that showed degenerative disc disease at L4-5 and L5-S1. There are specific clinical requests in this case for post-operative use of formal physical therapy as well as a cryotherapy device for the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**anterior lumbar discectomy and partial corpectomy with lumbar fusion at L3-L5 and left and right iliac crest bone graft: 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): 305-307.

**Decision rationale:** Based on California ACOEM Guidelines, anterior discectomy is not supported. The clinical records in this case would fail to necessitate the role of a three level lumbar fusion. This portion of operative intervention in this case would not be indicated. The claimant's clinical imaging does not demonstrate instability at the three requested surgical levels nor does physical examination demonstrate a radicular process at the three requested levels for which surgery would be warranted. The only clinical testing available for review is a lumbar discogram which is not supported as a reliable preoperative indicator. This coupled with the claimant's significant smoking history, lack of objective findings and imaging demonstrating instability would fail to necessitate the three level procedure as requested. Additionally, guidelines do not support fusion in the absence of fracture, spinal instability, spinal dislocation or spondylolisthesis and as such the fusion procedure would not be medically necessary.

**decompressive lumbar laminectomy from L3-S1 with bilateral fusion with segmental pedicle screw:** 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): 305-307.

**Decision rationale:** CA MTUS with respect to surgical referral state that there should be severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and failure of conservative treatment to resolve disabling radicular symptoms. The role of decompressive laminectomy based on California ACOEM Guidelines is not supported as the role of surgical intervention in this case has not yet been established.

**assistant surgeon:** 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.

**2-3 day inpatient hospital 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.

**Postoperative physical therapy (12 sessions):** 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 cool therapy:** 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.