

<b>Case Number:</b>	CM13-0035814		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	01/18/2012
<b>Decision Date:</b>	02/07/2014	<b>UR Denial Date:</b>	10/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2013

### 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 New Hampshire, New York, and Washington. 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 injured his back and his chronic low back pain. He reports his pain as being 7/10 and radiating into his box groin and testicles. The pain is associated with left lateral thigh calf and foot numbness. On physical examination the patient has reduced range of lumbar motion no focal motor or sensory deficits are present in the lower extremities. Motor and sensory function in the lower extremities is reportedly normal. MRI of the lumbar spine demonstrates disc degeneration at L4-5 and L5-S1. Disc protrusions at L4-5 and L5-S1 with moderate neural foraminal stenosis at L4-5 and L5-S1. X-rays of lumbar spine do not demonstrate any evidence of instability. Although the requesting provider does mention approximately 4 mm of retrolisthesis of L5 on the sacrum. At issue is whether lumbar spinal surgery is medically necessary at this time.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar laminectomy L4-S1 w/ posterior lumbar interbody fusion L4-5, L5-S1 with cages and posteriolateral fusion with instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Low Back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 308-310. Decision based on Non-MTUS Citation ODG Low Back Pain chapter

**Decision rationale:** This patient does not meet established criteria for lumbar spinal surgery at this time. There is no documented evidence of spinal instability radio graphically. There is no evidence of abnormal motion in the lumbar spine. There is no evidence of concern for tumor or the presence of fracture in the lumbar spine. The patient does not have any red flag indicators for spinal surgery such as progressive neurologic deficit fracture or tumor. Since no instability is present, and the patient has documentation of a normal neurologic examination in the bilateral lower extremities, there is no need for fusion or decompressive surgery. Additionally, imaging studies do not correlate with specific radiculopathy in the bilateral lower extremities. The patient does not have severe spinal stenosis on MRI imaging. There is no indication for decompressive surgery. Criteria for fusion and decompressive surgery are not met.

**Inpatient 5 day stay:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Low Back

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 308-310. Decision based on Non-MTUS Citation ODG Low Back Pain chapter

**Decision rationale:** Since his surgery is not needed, all other associated items are not needed.

**Cybertech back brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Low Back

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 308-310. Decision based on Non-MTUS Citation ODG Low Back Pain chapter

**Decision rationale:** Since his surgery is not needed, all other associated items are not needed. Guidelines do not establish the effectiveness of lumbar bracing for degenerative back pain without fracture and without postoperative state.

**Cold compression unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Low Back

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 308-310. Decision based on Non-MTUS Citation ODG Low Back Pain chapter

**Decision rationale:** Since his surgery is not needed, all other associated items are not needed.

**Bone growth stimulator for post-operative treatment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Low Back

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 308-310. Decision based on Non-MTUS Citation ODG Low Back Pain chapter

**Decision rationale:** Since his surgery is not needed, all other associated items are not needed.