

<b>Case Number:</b>	CM13-0061553		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	04/01/2010
<b>Decision Date:</b>	06/23/2014	<b>UR Denial Date:</b>	11/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2013

### 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 New York. 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:

Patient is a 53 male the date of injury April 1, 2010. The patient has chronic low back pain that radiates lower extremities. The physical examination reveals normal gait. There is tenderness to the low back muscles. Range of motion of the lumbar spine was reduced. Sensation was reduced and right L4, L5, and S1 dermatomes. Reflexes are normal. Motor strength was reduced at the flexion on the right. All of them muscle groups in a motor strength. An MRI lumbar spine reveals L4-5-1 millimeter foraminal disc protrusion. There is also L4-5 degenerative disc condition. Laminectomy changes are noted at L4-5. There is no central canal narrowing. At L5-S1 using 3 mm disc protrusion associated with an annular tear. Laminectomy changes are noted that his facet arthritis. There is no significant stenosis. Treatment to date including activity modification, medications, physical therapy, home exercise. Patient has been ESI without relief.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**INPATIENT SURGICAL PROCEDURE L4-S1 ANTERIOR POSTERIOR FUSION WITH CAGE AND INSTRUMENTATION:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 307-322.

**Decision rationale:** The patient does not meet establish criteria for additional lumbar surgery. Specifically, criteria for fusion surgery are not met. There is no documented evidence of instability, fracture, or tumor. There is no documentation of abnormal motion on flexion-extension views. In addition there is no need for lumbar decompression. There is no evidence of physical examination neurologic deficit that correlates with specific compression on lumbar imaging studies. Medical necessity for lumbar fusion has not been met. Lumbar fusion surgery is not medically necessary.

**VASCULAR 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.

**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.

**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.

**PRE-OPERATIVE MEDICAL CLEARANCE:** 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.

**POST-OPERATIVE DME: FRONT WHEEL WALKER, 3 IN 1 COMMODORE, 30 DAY RENTAL OF A COLD THERAPY UNIT, PNEUMATIC INTERMITTENT COMPRESSION DEVICE, BONE GROWTH STIMULATOR, LSO 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 surgery is not medically necessary, then all other associated items are not needed.

**MRI OF THE LUMBAR SPINE WITH CONTRAST:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, LOW BACK COMPLAINTS,

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MTUS low back pain

**Decision rationale:** Additional MRI imaging was not medically necessary, then patients are had an MRI. There is no documentation of significant neurologic deficit. There is no documentation of significant neural compression on MRI that the patient's previously had. There is no medical necessity for additional lumbar MRI.