

<b>Case Number:</b>	CM13-0061711		
<b>Date Assigned:</b>	05/07/2014	<b>Date of Injury:</b>	07/23/2010
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	11/05/2013
<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, has a subspecialty 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 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 injured worker is a 61-year-old male who reported an injury on 07/23/2010. The mechanism of injury involved heavy lifting. Current diagnoses include lumbar spinal stenosis and scoliosis. The injured worker was evaluated on 06/05/2013. Previous conservative treatment includes acupuncture therapy. The injured worker reported persistent pain, headache, sleep loss, depression, nervousness, anxiety, and numbness. Physical examination revealed severe tenderness to palpation of the lumbar spine with radiation into bilateral buttocks, reduced range of motion, positive straight leg raising bilaterally, positive facet compression testing bilaterally, diminished reflexes on the left, reduced sensation to light touch in the right lower extremity, and diminished strength in bilateral lower extremities. Treatment recommendations at that time included an L3-S1 decompression surgery and L4-5 fusion with instrumentation. It is noted, the injured worker underwent an MRI of the lumbar spine on 05/16/2013, which indicated diffuse spondylotic change, mild levoscoliosis, a 1-2 mm posterior disc bulge at L1-2, a 2-3 mm posterior disc bulge at L2-3 with moderate right foraminal narrowing, a 3-4 mm posterior disc bulge at L3-4 and L4-5 with severe canal stenosis and bilateral neural foraminal narrowing, and a 2-3 mm posterior disc bulge at L5-S1 with severe left neural foraminal narrowing.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DAY 1: ANTERIOR LUMBAR INTERBODY FUSION, RETROPERITONEAL OR PAR LATERAL APPROACH, AUTOGRAFT, ALLOGRAFT, SYNTHETIC GRAFT, BONE BORROW ASPIRATION, INSTUMENTATION, LLIAC CREST ONE GRAFT L3-4**

**AND L4-5 WITH NEUROMONITORING (TURELL) DAY 2: LUMBAR DECOMPRESSION AND INSTRUMENTED FUSION, PRESACRAL AND POSTE:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Low Back Chapter-Fusion.

**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 lower extremity symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion, and a failure of conservative treatment. Official Disability Guidelines state preoperative clinical surgical indications for a spinal fusion should include the identification and treatment of all pain generators, completion of physical medicine and manual therapy, demonstration of spinal instability on x-rays and/or CT myelogram, and a psychosocial evaluation. As per the documentation submitted, the injured worker has been previously treated with acupuncture therapy. However, there is no evidence of spinal instability on flexion and extension view radiographs. There is also no evidence of a psychosocial evaluation. Therefore, the injured worker does not currently meet criteria for the requested surgical procedure. As such, the request is not medically necessary and appropriate.

**2-3 NIGHT 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 med 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 med 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 med necessary, none of the associated services are medically necessary.

**TRIMOD BRACE FOR PURCHASE:** 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 med necessary, none of the associated services are medically necessary.

**BONE STIMULATOR FOR PURCHASE:** 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 med necessary, none of the associated services are medically necessary.

**POST-OPERATIVE AQUATIC PHYSICAL THERAPY FOR THE LUMBAR SPINE (2X4):** 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 med necessary, none of the associated services are medically necessary.

**POST-OPERATIVE LAND BASED PHYSICAL THERAPY FOR THE LUMBAR SPINE (2X6):** 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 med necessary, none of the associated services are medically necessary.

**CONTRAST COMPRESSION UNIT:** 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 med necessary, none of the associated services are medically necessary.

**FRONT-WHEELED WALKER:** 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 med necessary, none of the associated services are medically necessary.

**BEDSIDE COMMODOE:** 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 med necessary, none of the associated services are medically necessary.