

<b>Case Number:</b>	CM13-0069399		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	11/17/2010
<b>Decision Date:</b>	06/02/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/21/2013

### 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 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 39-year-old female who reported an injury on 11/17/2010. The mechanism of injury was not stated. Current diagnoses include cervical discopathy, right carpal tunnel syndrome/double crush syndrome, and lumbar facet arthropathy/discopathy/radiculitis. The injured worker was evaluated on 10/14/2013. The injured worker reported persistent lower back pain. Previous conservative treatment includes activity modification, physical therapy, and pain management. Physical examination of the lumbar spine revealed tenderness to palpation, restricted range of motion with guarding, and severe pain in the lower extremities. Treatment recommendations at that time included an L4-5 posterior lumbar interbody fusion with possible reduction of listhesis and correction of sagittal deformity. It is also noted, the injured worker underwent an MRI of the lumbar spine on 10/03/2013, which indicated 5% decrease in the height of the disc at L4-5 with dehydration of the disc, 3 mm posterior disc bulge, encroachment on the thecal sac and foramina bilaterally, and compromise of the exiting nerve roots bilaterally.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L4 TO L5 POSTERIOR LUMBAR INTERBODY FUSION WITH INSTRUMENTATION, NEURAL DECOMPRESSION, AND ILIAC CREST MARROW ASPIRATION / HARVESTING, POSSIBLE JUNCTIONAL LEVELS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307.

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

**Decision rationale:** The 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 electrophysiological evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state preoperative clinical surgical indications for a spinal fusion should include identification and treatment of all pain generators, completion of manual and physical therapy, demonstration of spinal instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and completion of a psychosocial evaluation. As per the documentation submitted, the injured worker does not appear to meet criteria for the requested procedure. There is no evidence of documented instability on flexion and extension view radiographs. There is also no evidence of a psychosocial evaluation prior to the requested surgical procedure. Therefore, the request for L4 TO L5 posterior lumbar interbody fusion with instrumentation, neural decompression, and iliac crest marrow aspiration / harvesting, possible junctional levels is not medically necessary.

**FRONT WHEEL 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 medically necessary, none of the associated services are medically necessary.

**ICE 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 medically necessary, none of the associated services are medically necessary.

**BONE STIMULATOR:** 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.

**TLSO 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 the primary procedure is not medically necessary, none of the associated services are medically necessary.

**3 - 1 COMMODE:** 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.

**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.

**THREE (3) DAYS INPATIENT 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.

**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.