

<b>Case Number:</b>	CM13-0069420		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	07/27/2001
<b>Decision Date:</b>	05/23/2014	<b>UR Denial Date:</b>	11/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2013

### 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 68-year-old male who reported an injury on July 27, 2001. Current diagnoses include spinal stenosis at L3-4, cervical stenosis at C4-5, cervical radiculopathy, bilateral shoulder impingement, status post spinal decompression and fusion, and status post shoulder rotator cuff repair. The injured worker was evaluated on December 04, 2013. The injured worker reported persistent lower back pain with radiation in the lower extremity. The injured worker has been previously treated with physical therapy, medications, and epidural steroid injections. Physical examination on that date revealed limited lumbar range of motion, positive straight leg raising, decreased strength bilaterally, and decreased sensation in the L4 distribution. Treatment recommendations at that time included decompression and fusion at L3-4.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **POSTERIOR LUMBAR DECOMPRESSION, FUSION, AND INSTRUMENTATION:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

**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, Decompression, Fusion.

**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 one (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 there are two (2) common types of spine surgery decompression procedures, including microdiscectomy or open decompression. Spinal fusion is indicated when all pain generators have been identified and treated, all physical medicine and manual therapy interventions have been completed, x-rays demonstrate spinal instability, spine pathology is limited to 2 levels, and a psychological screening has been completed. There is no evidence of significant instability upon flexion and extension view radiographs. There is also no documentation of a psychological screening. There were no imaging studies provided for review. Based on the aforementioned points, the injured worker does not currently meet criteria for the requested procedure. Based on the clinical information received, the request is not medically necessary.