

<b>Case Number:</b>	CM14-0005896		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	07/27/2009
<b>Decision Date:</b>	06/23/2014	<b>UR Denial Date:</b>	12/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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 Fellowship 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 patient is a 42-year-old female with a July 27, 2009 date of injury. The December 5, 2013 progress report indicates persistent low back pain radiating to the lower extremities with numbness and tingling. Physical exam demonstrates lumbar tenderness, positive straight leg raise test, dysesthesia in the L5 and S1 dermatomes. A December 19, 2012 lumbar MRI demonstrates, at L3-4, a 3-mm posterior disk protrusion with encroachment on the thecal sac and neural foramina bilaterally with compromise on the traversing left nerve root and the exiting nerve roots bilaterally; and, at L4-5, a 3-4 mm posterior disk protrusion with encroachment on the foramen bilaterally. Treatment to date has included medication, TENS unit, activity modification, intramuscular injections. There is documentation of a previous December 13, 2013 adverse determination for lack of motor or reflex impairment, no documentation of specific physical findings corresponding to worsening symptoms, and lack of documented instability or listhesis on imaging.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L3-L5 POSTERIOR LUMBAR INTERBODY FUSION WITH INSTRUMENTATION, NEURAL DECOMPRESSION, AND ILIAC CREST MARROW ASPIRATION / HARVESTING POSSIBLE JUNCTIONAL LEVELS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 Official Disability Guidelines (ODG) Low Back Chapter, Decompression, Fusion X Other Medical Treatment Guideline or Medical Evidence: AMA Guides Radiculopathy, Instability.

**Decision rationale:** The California MTUS Guidelines state that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair; and failure of conservative treatment. In addition, guidelines state that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. While the patient presents with recalcitrant radiculopathy, the fusion portion of the surgery is in question as there is no imaging evidence of functional spinal unit failure, degenerative spondylolisthesis or dynamic instability. Flex-ex views were not obtained. There is no evidence of psychological clearance for the proposed procedure. Therefore, the request 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.

**THORACIC LUMBAR SACRAL ORTHOSIS (TLSO): 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) IN ONE (1) COMMUNE: 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.

**INPATIENT STAY; THREE (3) DAYS: 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.

**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.