

<b>Case Number:</b>	CM14-0012394		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	07/23/2013
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	01/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2014

### 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 and is licensed to practice in Minnesota. 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:

This is a 36-year-old male with a 7/23/13 date of injury. A 1/3/14 progress report by [REDACTED] describes low back pain and limited range of motion radiating down to both legs with numbness and tingling. Sensory exam revealed decreased sensation to light touch over the right posterior thigh, leg, and foot as well as the left posterior thigh. It states that the patient saw [REDACTED] for a spine consultation on 12/9/13. There is a request for authorization from [REDACTED] dated 1/16/14 for anterior/posterior fusion at L5-S1. A 12/9/13 progress report by [REDACTED] describes radiating low back pain to the bilateral legs and weakness. Range-of-motion is described as limited. Reflexes are normal. There is no comprehensive neurologic exam or nerve root tension signs. The doctor recommended anterior and posterior L4-S1 fusion. A 12/9/13 progress report from [REDACTED] described low back pain radiating into both legs with numbness and tingling. Subjectively there was weakness of both legs. The physical exam showed that the patient walked with a normal heel-and toe gait without limping. Range of motion was stated as limited. Reflexes were normal. There was right-sided hypoesthesia at L4, L5, and S1. There was no motor exam. The patient had a course of physical therapy and chiropractic treatment. The patient was placed off of work in September of 2013. X-rays showed mild narrowing at L5-S1 as well as multilevel facet subluxation and elongation. The request included anterior and posterior lumbar fusion at L5-S1. A 10/15/13 progress report is unsigned. It is however from the [REDACTED]. She describes radicular pain and a normal neurologic examination. Recommendation was to continue and complete the remaining chiropractic treatment. A 9/10/13 MRI of the lumbar spine showed a central broad-based disk bulge measuring 7 mm at L5-S1 with impression on the thecal sac and moderate-severe spinal canal stenosis. At L4-5, there was a disk bulge measuring 4 mm with mild bilateral hypertrophy of the facets, mild bilateral foraminal narrowing, and mild spinal canal stenosis. A 11/20/13 progress

report by [REDACTED] states that the patient is working modified duties. There is low back pain radiating down the bilateral legs as shooting pain. It occasionally radiates down to the level of the ankle. The patient complains of weakness to the right leg. Physical exam shows generalized tenderness and pain with range of motion. No neurologic exam. Authorization was requested for spinal consultation with [REDACTED].

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Anterior/Posterior Fusion at L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non- MTUS Citation ODG.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines and AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition criteria for Instability page 379.

**Decision rationale:** The progress report and request for authorization dated 12/9/13 had requested L4-S1 fusion. The request presented here is anterior and posterior fusion at L5-S1. The requests are not the same. There is evidence of radicular pain, but there are no reliable neurologic findings on examination. There is evidence of severe canal stenosis and a fairly large disk protrusion at L4-5, but nothing that would warrant fusion at L4-5. The request would need to be reconciled prior to any authorization. As such, the request is not medically necessary and appropriate.

#### **Cold therapy unit: Upheld**

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

#### **Combo Care 3 Stim Unit: Upheld**

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

#### **Purchase of DVT Max Unit: Upheld**

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

#### **3-5 Day Hospital Stay: Upheld**

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

#### **Pre-Op Consult with Vascular Surgeon: Upheld**

Since the primary procedure is not medically necessary, none of the associated services are

medically necessary.

**Assistance Surgeon: Upheld**

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

**Pre-Op Internal Medicine/Cardiology Clearance: Upheld**

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

**Intraoperative Spinal Cord Monitoring and Cell Saver: Upheld**

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

**Units of Autologous Blood Donation: Upheld**

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

**Post-Op Physical Therapy, #32 Visits: Upheld**

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

**LSO Brace: Upheld**

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

**Bone Graft Stimulator: Upheld**

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

**Front Wheeled Walker: Upheld**

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

**Grabber: Upheld**

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

**Post-operative Lyrica 1-2 every 4-6 hours as needed: Upheld**

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

**Post-operative Narcotics- Percocet 1-2 every 4-6 hours as needed: Upheld**

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

**Elevated Toilet seat: Upheld**

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