

<b>Case Number:</b>	CM14-0013197		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	06/02/2010
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	01/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2014

### 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 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:

This is a 57-year-old male with a 6/2/10 date of injury. It is described as gradual onset of pain in the low back attributed to the highly physical demands of fighting fires as well as performing rescues. 1/6/14 progress report describes low back pain aggravated by usual activities. Physical exam of the lumbar spine shows tenderness, seated nerve root test is positive and dysesthesias L4-S1 dermatomes. Recommendations were to continue chiropractic care while the patient is awaiting lumbar spine surgery. 12/2/13 progress report describes continued symptomatology in the lumbar spine with extension into the lower extremities. Lumbar spine exam showed tenderness, guarding, and dysesthesias in the L5-S1 dermatome. Seated nerve root test is positive. The diagnoses include lumbar discopathy and electrodiagnostic evidence of left L5-S1 radiculopathy. Surgical recommendation was made in the form of L3-L5 posterior lumbar interbody fusion. 10/23/13 EMG showed evidence of L5-S1 radiculopathy. 10//13 MRI of the lumbar spine showed at L3-4, moderate disk osteophyte complex, hypertrophic facet joint changes, mild canal and moderate foraminal stenosis. At L4-5, moderate diffuse disk bulge/osteophyte complex, hypertrophic facet joints, mild canal stenosis and moderate foraminal stenosis. At L5-S1, mild diffuse bulge/osteophyte complex, asymmetric to the left with hypertrophic facet joints, the central canal and right foramen remain grossly patent and moderate left foraminal stenosis.

### 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 LLIAC CREST MARROW ASPIRATION/HARVESTING POSSIBLE JUNCTIONAL LEVELS: Upheld**

**Claims Administrator 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 ; AMA Guides.

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

**Decision rationale:** The request for L3-4 and L4-5 posterior lumbar interbody fusion with neural decompression is not medically necessary. There is no clear documentation of any dermatomal distribution of pain or corresponding neural findings on examination that correspond to the levels in question. The electrodiagnostic studies were positive at L5-S1 on the left. According to the MTUS guidelines, fusion can be recommended when there is evidence of dynamic instability that has not been described in this case.

**ASSISTANT SURGEON: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopedic Surgeons Position Statement.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**FRONT WHEEL WALKER: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**ICE UNIT PURCHASE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG), Knee Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, and [http://www.odgtwc.com/odgtwc/Knee\\_files/bcbs\\_bonce\\_stim.htm](http://www.odgtwc.com/odgtwc/Knee_files/bcbs_bonce_stim.htm).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**THORACOLUMBOSACRAL ORTHOSIS (TLSO):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG), Low Back Chapter.

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

**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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter and <http://circ.ahajournals.org/cgi/content/full/116/17/e418>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**THREE DAY 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.