

<b>Case Number:</b>	CM14-0018917		
<b>Date Assigned:</b>	05/07/2014	<b>Date of Injury:</b>	06/26/2011
<b>Decision Date:</b>	07/09/2014	<b>UR Denial Date:</b>	01/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/14/2014

### 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 Texas. 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 33 year old male who reported an injury to his lumbar region on June 26, 2011. The clinical note dated 01/23/14 indicates the injured worker complaining of low back pain with radiation of pain into both buttocks, left greater than right. The injured worker also reported persistent pain radiating to the left side. The injured worker also reported bladder and bowel incontinence. Upon exam, tenderness was identified at the mid and distal lumbar segments on the left with spasms. The injured worker also demonstrated range of motion limitations. Dysesthesia was identified in the L4 and L5 dermatomes on the left. The clinical note dated 10/22/13 indicates the injured worker utilizing Terocin patches for pain relief. The clinical note dated 08/22/13 indicates the injured worker having failed all conservative treatments to include activity modifications, pain management, physical therapy, and 2 epidural steroid injections. The injured worker also reported bowel and bladder dysfunction as well as progressive neurologic deficits in the lower extremities. Dysesthesia was identified at the L4-5 dermatomes on the left. Tenderness was identified at the mid and distal lumbar segments. The MRI of the lumbar spine dated 08/07/13 revealed a 5-6mm posterior disc extrusion at the L3-4 level. Significant encroachment was identified on the thecal sac with significantly acquired canal stenosis. Compromise of the traversing nerve roots was also revealed. A 3mm posterior disc bulge was also identified at L4-5 touching the thecal sac and encroachment on the foramina. Compromise of the exiting nerve roots was also revealed bilaterally. The utilization review dated 01/22/14 resulted in a denial for an L2 through L4 posterior lumbar interbody fusion as well as the requested DME and postoperative medications.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **L2 to L4 POSTERIOR LUMBAR INTERBODY FUSION (PLIF) WITH REALIGNMENT OF THE JUNCTIONAL KYPHOTIC DEFORMITY THAT IS PRESENT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request for an L2 through L4 posterior lumbar interbody fusion with realignment of the junctional kyphotic deformity is non-certified. The documentation indicates the injured worker complaining of low back pain with radiculopathy findings in the lower extremities. A fusion is indicated in the lumbar region provided the injured worker meets specific criteria to include imaging studies confirming the injured worker's pathology and the injured worker has completed all conservative treatments as well as a psychosocial screening. There is an indication the injured worker is demonstrating significant findings at the L2-3 and L3-4 levels confirmed by magnetic resonance imaging (MRI). However, no x-rays were submitted confirming the injured worker's instability. Additionally, no information was submitted regarding the injured worker's completion of a psychosocial screening addressing any confounding issues as well as potential outcomes of the pending surgery. Given these factors, this request is not indicated as medically necessary.

### **DURABLE MEDICAL EQUIPMENT (UNSPECIFIED):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Policy Durable Medical Equipment.

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

**Decision rationale:** No information was submitted regarding the specific durable medical equipment. Therefore, it would be unclear as to the specific symptoms being addressed. Therefore, this request is not indicated as medically necessary.

### **POSTOPERATIVE MEDICATION (UNSPECIFIED):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-78.

**Decision rationale:** Given the requested surgery resulting in a denial, the additional request for postoperative medication is not medically necessary. However, the specific medication was not provided in the documentation. Therefore, it is unclear if the injured worker would likely benefit from the use of postoperative medicines.