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| <b>Case Number:</b>   | CM14-0117692 |                              |            |
| <b>Date Assigned:</b> | 08/06/2014   | <b>Date of Injury:</b>       | 09/27/2010 |
| <b>Decision Date:</b> | 09/12/2014   | <b>UR Denial Date:</b>       | 07/16/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/25/2014 |

### 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 Neurological 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 records, presented for review, indicate that this 47 year-old individual was reportedly injured on September 27, 2010. The mechanism of injury was noted as lifting a piece of equipment. The most recent progress note, dated August 6, 2014 indicated that there were ongoing complaints of low back pain. The physical examination demonstrated tenderness to palpation, a decreased range of motion, and some subtle neurological changes lower extremity. Diagnostic imaging studies objectified electrodiagnostic evidence of a verifiable radiculopathy in the right lower extremity. MRI also noted an annular tear and disc protrusion at L4-L5. Flexion and extension films were reported to be completed, but the results are noted. Previous treatment included transforaminal epidural steroid injections, multiple medications, imaging studies, and pain management techniques. A request had been made for lumbar surgery and was not certified in the pre-authorization process on July 16, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L4-L5 Arthrodesis (including laminectomy and/or discectomy): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 12th Edition, Web, Low Back, 2014, Fusion.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** As noted in the ACOEM guidelines, "spinal fusion is not recommended for chronic low back pain" and is not indicated in the absence of fracture, dislocation, tumor or infection. When noting the findings of MRI, there is objective occasion of a disc herniation. However, the flexion/extension films did not establish any instability. Elected diagnostic studies noted a radiculopathy, but there is no evidence of infection, dislocation or fracture. Therefore, when following the parameters outlined in the ACOEM guidelines for a lumbar fusion, the medical necessity for surgery is not met. This request is not medically necessary.

**L4-L5 Arthrodesis, posterior interbody technique:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 12th Edition, Web, Low Back, 2014, Fusion.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** As noted in the ACOEM guidelines, "spinal fusion is not recommended for chronic low back pain" and is not indicated in the absence of fracture, dislocation, tumor or infection. When noting the findings of MRI, there is objective occasion of a disc herniation. However, the flexion/extension films did not establish any instability. Elected diagnostic studies noted a radiculopathy, but there is no evidence of infection, dislocation or fracture. Therefore, when following the parameters outlined in the ACOEM guidelines for a lumbar fusion, the medical necessity for surgery is not met. This request is not medically necessary.

**L4-L5 Arthrodesis, posterior with instrumentation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 12th Edition, Web, Low Back, 2014, Fusion.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** As noted in the ACOEM guidelines, "spinal fusion is not recommended for chronic low back pain" and is not indicated in the absence of fracture, dislocation, convocations of tumor or infection. When noting the findings of MRI, there is objective occasion of a disc herniation. However, the flexion/extension films did not establish any instability. Elected diagnostic studies noted a radiculopathy, but there is no evidence of infection, dislocation or fracture. Therefore, when following the parameters outlined in the ACOEM guidelines for a lumbar fusion, the medical necessity for surgery is not met. This request is not medically necessary.

**Surgical assistant:** 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.

**Lumbar brace:** 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.

**In-patient hospital stay:** 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.

**Post-op Physical Therapy, lumbar, 18 sessions:** 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.

**Island Bandage (box), quantity 1:** 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.