

<b>Case Number:</b>	CM14-0136286		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	07/19/2007
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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 Orthopedic Surgeon 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 62 year old female who sustained an injury on 07/19/07 to the bilateral posterior neck and bilateral lower back. The injured worker has been followed for persistent complaints of low back pain. There is a prior history of lumbar fusion from L4 to S1 in 2008. Multiple medications were noted to include non-steroidal anti-inflammatory drugs (NSAIDs) and analgesics. No prior imaging was available for review. The injured worker was seen on 06/04/14 for ongoing complaints of neck and low back pain. The physical exam noted limited lumbar range of motion without radicular findings. The injured worker was recommended for epidural steroid injections at this evaluation. The requested lumbar fusion procedures at L3 to L4 with posterior spinal fusion from L3 to S1 with a surgical assistant, three day length of stay, and eighteen postoperative physical therapy sessions were denied by utilization review on 07/16/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Surgical assistant:** Upheld

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

**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: American Association of Orthopaedics Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics

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

**3 days inpatient stay:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Hospital length of stay

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

**L4-S1 removal of instrumentation and exploration, L3-L4 transforaminal lumbar interbody fusion and L3-S1 posterior spinal fusion/posterior segmental instrumentation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The proposed surgical procedures to include L4 to S1 removal of instrumentation and exploration, L3 to L4 transforaminal lumbar interbody fusion and L3 to S1 posterior spinal fusion/posterior segmental instrumentation would not be supported as medically necessary. The clinical documentation provided for review describes minimal nonoperative treatment outside of recommended medications. The last report recommended epidural steroid injections. There was no documentation regarding any recent physical therapy. Furthermore, the clinical documentation did not include any recent imaging that would support the request as medically necessary.

**18 physical therapy visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

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