

<b>Case Number:</b>	CM14-0164626		
<b>Date Assigned:</b>	11/04/2014	<b>Date of Injury:</b>	07/14/2008
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	10/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2014

### 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 Spine 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 40-year-old male who reported an injury on 07/14/2008. The mechanism of injury was not stated. The current diagnosis is lumbar radiculopathy. The injured worker was evaluated on 09/10/2014 with complaints of ongoing lower back pain and left lower extremity radiculopathy. Previous conservative treatment is noted to include medication management, physical therapy and epidural steroid injection. The current medication regimen includes Norco 7.5/325 mg. Physical examination revealed 4/5 weakness of dorsiflexion on the right, 3/5 weakness of left dorsiflexion, numbness and tingling in the bilateral lower extremities, an antalgic gait, and negative swelling and tenderness. Treatment recommendations at that time included an L4-5 instrumented fusion and decompression. There was no Request for Authorization form submitted for this review. It is noted that the injured worker underwent an MRI of the lumbar spine on 07/15/2014, which revealed bilateral neural foraminal stenosis and central spinal stenosis at L4-5, left foraminal disc bulge at L3-4, bilateral neural foraminal and lateral recess stenosis at L5-S1, and multilevel degenerative changes.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Lumbar Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (Spinal)

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month clear clinical, imaging and electrophysiologic evidence of a lesion, and failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. As per the documentation submitted, the injured worker has been previously treated with physical therapy, epidural steroid injection and medication management. However, there is no documentation of a psychosocial screening. There is also no documentation of spinal instability upon flexion and extension view radiographs. There is no evidence of a significant functional deficit upon physical examination. Based on the clinical information received, the request is not medically necessary at this time.

**Associated surgical service: Post-operative physical therapy three times per week for six weeks for a total of 18 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (Spinal)

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

**Associated surgical service: One (1) box island dressings:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation SOLUTIONS Wound Care Algorithm, Princeton (NJ): ConvaTec; 2005. 8p.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (Spinal)

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

**Associated surgical service: LSO brace: 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, Back Brace, Post Operative (Fusion)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (Spinal)

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

**Arthrodesis, posterior posterolateral technique, single level; lumbar (with lateral transve): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Lumbar Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (Spinal)

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month clear clinical, imaging and electrophysiologic evidence of a lesion, and failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. As per the documentation submitted, the injured worker has been previously treated with physical therapy, epidural steroid injection and medication management. However, there is no documentation of a psychosocial screening. There is also no documentation of spinal instability upon flexion and extension view radiographs. There is no evidence of a significant functional deficit upon physical examination. Based on the clinical information received, the request is not medically necessary at this time.

**Posterior non-segmental instrumentation (eg, harrington rod technique, pedicle fixation across): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Lumbar Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (Spinal).

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month clear clinical, imaging and electrophysiologic evidence of a lesion, and failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. As per the documentation submitted, the injured worker has been previously treated with physical therapy, epidural steroid injection and medication management. However, there is no documentation of a psychosocial screening. There is also no documentation of spinal instability upon flexion and extension view radiographs. There is no evidence of a significant functional deficit upon physical examination. Based on the clinical information received, the request is not medically necessary at this time.