

<b>Case Number:</b>	CM14-0176661		
<b>Date Assigned:</b>	10/29/2014	<b>Date of Injury:</b>	08/09/2010
<b>Decision Date:</b>	12/05/2014	<b>UR Denial Date:</b>	10/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/24/2014

### 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 67-year-old male who reported an injury on 08/09/2010. The injured worker was reportedly sitting on a milk crate when it slipped out from underneath him, causing him to land on his tailbone. The current diagnoses include disorder of the coccyx, mood disorder and low back pain. The injured worker was evaluated on 10/02/2014. The current medication regimen includes Dexilant, Lyrica, Cymbalta, Neurontin, Soma, Ambien, Seroquel, and Oxycontin. It is noted that the injured worker has developed worsening lower limb pain, weakness and numbness affecting his overall ability to self-care. Physical examination was not provided on that date. Treatment recommendations included continuation of the current medication regimen. The injured worker then underwent a presurgical psychological evaluation on 08/22/2014. It is noted that the injured worker has been previously treated with medication, injections, TENS therapy, physical therapy, and H-wave stimulation. The injured worker has also tried a spinal cord stimulator and an intrathecal pump. The injured worker maintains a diagnosis of depressive disorder. The provider noted several psychological risk factors that make the injured worker a less than optimal candidate for a surgery. The risk factors were not an absolute contraindication; however, with a fair degree of certainty, the prognosis for pain control from surgery was not good. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated Surgical Service: L1-L5 anterolateral discectomy and fusion and L5-S1 hardware removal L1-S1 posterior instrumented fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, 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 exhausted conservative treatment. However, there was no recent physical examination provided for review. There is no documentation of a significant functional limitation. There is no evidence of spinal instability upon flexion and extension view of radiographs. The Official Disability Guidelines do not recommend a spinal fusion at more than 2 levels. Therefore, the request for an L1-5 anterolateral discectomy and fusion and an L1-S1 posterior instrumented fusion cannot be determined as medically appropriate. Additionally, it was noted that the injured worker maintains several psychological risk factors and is a less than optimal candidate for any surgery. Based on the clinical information received and the above mentioned guidelines, the request is not medically appropriate at this time.

**Associated Surgical Service: Three (3) day inpatient stay: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Fusion

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary.

**Associated Surgical Service: Surgery assistant: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary.

**Associated Surgical Service: Three in one Commode:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary.

**Associated Surgical Service: Lumbo brace:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary.

**Associated Surgical Service: Front wheel walker purchased:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary.