

<b>Case Number:</b>	CM14-0020554		
<b>Date Assigned:</b>	04/30/2014	<b>Date of Injury:</b>	08/25/2012
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	02/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2014

### 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, has a subspecialty in Spine Surgery and is licensed to practice in New York. 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:

Patient has a date of injury of August 25, 2012. He complains of chronic low back pain. Physical examination reveals decreased reasonable motion and a positive straight leg raise bilaterally. There is weakness of right ankle dorsiflexion and decreased sensation of the posterior lateral thigh. Patient's though conservative measures included chiropractic care, physical therapy, pigmented of epidural steroid injections. MRI reveals L4-5 left disc protrusion. There is an annular tear at L4-5 and a central disc extrusion at L5-S1. Neurophysiologic testing shows bilateral chronic active L5-S1 radiculopathy. At issue is whether surgical fusion is medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ANTERIOR LUMBAR INTERBODY FUSION SURGERY, POST INSTRUMENTATION POSTEROLATERAL FUSION 360 DEGREE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307-322.

**Decision rationale:** The patient does not meet establish criteria for lumbar fusion surgery. Specifically there is no evidence of lumbar instability. In addition, the patient does not have any red flag indicators for spinal fusion surgery such as fracture, tumor, and progressive neurologic deficit. Lumbar fusion is not more likely than conservative measures to relieve chronic axial back pain patient with multiple levels of disc degeneration. Established criteria for lumbar fusion are not met. Lumbar fusion is not medically necessary.

**3 DAYS INPATIENT 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.

**ASSISTANT SURGEON:** 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.

**PRE-OP CLEARANCE:** 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.

**DME BACK 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.

**DME WALKER:** 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.

**DME BONE GROWTH STIMULATOR PURCHASE:** 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 X 18 FOR LUMBAR:** 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.