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| <b>Case Number:</b>   | CM14-0021387 |                              |            |
| <b>Date Assigned:</b> | 05/07/2014   | <b>Date of Injury:</b>       | 11/17/2011 |
| <b>Decision Date:</b> | 07/09/2014   | <b>UR Denial Date:</b>       | 01/30/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/20/2014 |

### 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 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:

The patient is a female with date of injury of November 17, 2001. Lumbar MRI shows L4-5 disc bulge with bilateral foraminal narrowing. There is disc degeneration L1-L5 S1. Physical examination shows muscle spasm the lumbar spine reduced range of motion lumbar spine. Straight leg raising is positive on the left. There is 4+ over 5 right lower extremity strengthening 4-5 left lower extremity. Deep tendon reflexes are diminished at the knees and absent at the left hamstring and Achilles. The patient was treated with physical therapy acupuncture which is provided temporary relief. The patient takes multiple medications. At issue is whether lumbar spinal fusion surgery 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 AT L4-5 LEVEL: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary.

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

**Decision rationale:** The patient does not meet established criteria for lumbar fusion. There is no evidence of instability in the medical records. There is no evidence of abnormal motion lumbar segments on flexion-extension views. The patient does not have any red flag indicators for spinal fusion surgery such as fracture, tumor, or progressive neurologic deficit. Spinal fusion surgery at this time is not medically necessary.

**1-2 DAY 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.

**POSTOPERATIVE PHYSICAL THERAPY (2) TIMES PER WEEK FOR (6) WEEKS:**  
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-OPERATIVE MEDICAL 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.