

<b>Case Number:</b>	CM14-0032725		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	02/17/2011
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	02/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 25-year-old female with date of injury of February 17, 2011. The patient has chronic low back pain. The pain radiates to both legs. On physical examination there is global weakness in the bilateral lower extremities. There is reduced sensation at L5 and S1. Straight leg raise is positive. Lumbar MRI from 2013 shows L3-4 disc bulge. At L4-5 there is moderate canal stenosis with foraminal narrowing. There is also a 10 mm central disc protrusion obliterating the thecal sac. At L5-S1 there is a broad-based disc bulge. This causes mild canal stenosis. Conservative care has included activity modification, medications, physical therapy, chiropractic treatment, acupuncture, and epidural steroid injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L4-5 and L5-S1 bilateral laminotomies, discectomies, transforaminal lumbar interbody fusion (TLIF) with cage and instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation American Medical Association Guides, Radiculopathy American Medical Association Guides, Evaluation of Permanent Impairment, fifth edition criteria for instability (page 379) Official Disability Guidelines, Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-322.

**Decision rationale:** The patient does not meet establish criteria for multilevel fusion surgery. Specifically, there is no documentation of lumbar instability at any level. There is no evidence of flexion-extension views showing instability. In addition the patient does not have any red flag indicators for spinal fusion surgery such as fracture, tumor, or progressive neurologic deficit. The patient does not meet establish criteria for lumbar decompressive surgery. Specifically there is no clear correlation between the physical exam findings and the medical imaging studies. Physical exam findings do not document specific radiculopathy in the region of an isolated nerve root. There is no clear correlation between MRI imaging and patient's physical examination. As such, the request is not medically necessary.

**Post-op Physical Therapy 3 times a 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.

**Lumbar Sacral Orthosis (LSO) Brace:** Upheld

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

**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.

**Pneumatic intermittent compression device:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg Chapter.

**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.