

<b>Case Number:</b>	CM14-0033220		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	10/26/2012
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	03/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/17/2014

### 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 24-year-old male with injury of October 26, 2012. Patient has chronic back pain. He takes narcotic pain medication. Physical exam reveals full strength in the lower extremities with no motor deficit. He notes numbness in the dorsum of the feet and L5 distribution. MRI from 2013 shows L5-S1 broad-based disc bulge. There is foraminal narrowing at L5-S1. Patient had a previous MRI in October 2012 that showed L4-5 and L5-S1 disc protrusions. There was mild to moderate canal stenosis at these levels. The patient has had medications, activity modifications, physical therapy and epidural steroid injection. At issue is whether L4-S1 posterior fusion with instrumentation is medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **L4-S1 Anterior, Posterior Fusion with Instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines; AMA Guides to the Evaluation of Permanent Impairment, Fifthe Edition criteria for Instability, page 379.

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

**Decision rationale:** This patient does not meet establish criteria for two-level lumbar fusion surgery. Specifically the medical records do not document any instability the lumbar spine. Also, the patient does not have any red flag indicators for spinal fusion surgery such as fracture, tumor, or progressive neurologic deficit. Established criteria for lumbar fusion are not met. Lumbar fusion in cases of multiple levels of degenerative disc condition is not more likely to relieve axial back pain symptoms and continued conservative non-operative measures. Two-level fusion surgery is not medically necessary.

**Co-Surgeon/Assistant:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics.

**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 Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:Odg low back chapter.

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

**Bone Growth Stimulator and Fitting:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back Chapter and [http://www.odg-twc.com/odgtwc/knee\\_files/bcbs.bone\\_stim.htm](http://www.odg-twc.com/odgtwc/knee_files/bcbs.bone_stim.htm).

**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.