

<b>Case Number:</b>	CM14-0034124		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	01/15/2010
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	03/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2014

### 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 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 64-year-old male who reported an injury on 01/15/2010. The mechanism of injury was not specifically stated. Current diagnoses include cervical discopathy, bilateral shoulder internal derangement, bilateral carpal tunnel syndrome, upper back pain, lumbar discopathy, and rule out internal derangement, status post right knee surgery in 2012 and status post left knee surgery. The injured worker was evaluated on 02/03/2014 with complaints of ongoing lower back pain with radiation into the bilateral lower extremities. Previous conservative treatment includes activity modification, physical therapy and pain management. Physical examination of the lumbar spine revealed tenderness to palpation, guarding, restricted range of motion, and a radicular pattern involving the L3-S1 dermatomes, diminished sensation, positive straight leg raise and foot drop. Treatment recommendations at that time included a posterior lumbar interbody fusion with instrumentation. It is noted that the injured worker underwent an MRI of the lumbar spine on 01/22/2014, which indicated 6 mm of anterolisthesis at L4-5 with nerve root compromise and a disc protrusion at L5-S1 with neural foraminal encroachment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L2-L5 possibly L5-S1 posterior lumbar interbody fusion (PLIF) with instrumentation at L4-L5 and neural decompression: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC Low Back Procedure Summary last updated 02/13/2014.

**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:** The California MTUS/ACOEM Practice Guidelines state that a referral for a surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitation for more than 1 month; clear clinical, imaging and electrophysiological evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state that preoperative surgical indications for a spinal fusion should include identification and treatment of all pain generators, completion of all physical medicine and manual therapy interventions, documented instability upon CT myelogram or x-ray, 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 were no flexion and extension view radiographs submitted for review. There was also no documentation of a psychosocial screening prior to the request for a lumbar fusion. Based on the clinical information received and the above-mentioned guidelines, the L2-L5 possibly L5-S1 posterior lumbar interbody fusion (PLIF) with instrumentation at L4-L5 and neural decompression is not medically necessary.

**Bone stimulator:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC Low Back Procedure Summary last updated 10/09/2013.

**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. Therefore, the Bone stimulator is not medically necessary.

**Commode:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary. Therefore, the Commode is not medically necessary.

**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. Therefore, the request is non-certified.

