

<b>Case Number:</b>	CM14-0034964		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	11/20/2013
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	03/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2014

### 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 chronic low back pain. She continues to experience pain despite conservative measures. She had previous lumbar surgery. Flexion-extension views of the lumbar spine revealed disc space collapse at L5-S1. There is no evidence of instability with abnormal motion greater than 5 mm on flexion-extension views. The patient has radicular pain consistent with S1 dermatomal distribution. There is absent Achilles reflex on the left. Ankle plantarflexion shows weakness. Additionally, previous operative reports indicate that the patient had cerebrospinal fluid leaks postoperatively with previous lumbar decompressive surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 posterior lumbar interbody fusion (PLIF) with revision decompression and possible dural repair:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-322. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back chapter.

**Decision rationale:** This patient does not meet criteria for lumbar fusion surgery. Specifically, there is no documented abnormal instability on flexion-extension views. Flexion-extension views do not demonstrate significantly abnormal motion in translation. Also, there is no evidence of fracture, tumor or any other red flag indicators for spinal fusion surgery. The patient previous lumbar surgery consisting of decompression. There is no evidence that there is subsequent instability. There is also no need for dural pair surgery is the patient does not have an active CSF leak. Lumbar surgery is not medically necessary.

**Medical Clearance with Internist:** 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.

**Front Wheel 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.

**Ice unit:** 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.

**Bone Stimulator:** 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.

**Thoracolumbar sacral orthosis (TLSO) brace:**

**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.

**3-in-1 commode:** 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.