

<b>Case Number:</b>	CM14-0036973		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	06/10/2004
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	03/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2014

### 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 California. 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 43-year-old male who reported an injury on 06/10/2004. The mechanism of injury involved heavy lifting. The current diagnosis is status post L5-S1 disc arthroplasty with continued back pain. The injured worker was evaluated on 10/15/2013 with complaints of persistent lower back pain. The injured worker also reported numbness in the second and third toes. A disc arthroplasty was performed in 12/2005 without improvement in symptoms. Previous conservative treatment includes physical therapy, transforaminal injections and facet injections. The current medication regimen includes Norco 10 mg, Celebrex 200 mg, and Zanaflex 4 mg. Physical examination on that date revealed a well healed anterior midline low abdominal incision, 5 degrees extension, 30 degrees forward flexion, 10 degrees lateral flexion, intact sensation, 5/5 motor strength, 2+ deep tendon reflexes, negative straight leg raising and negative FABRE testing. It was noted at that time, the injured worker was a candidate for a fusion surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Posterior Fusion at L5-S1 for the Lumbar and or Sacral Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure Summary, Patient selection Criteria for Lumbar Spinal Fusion.

**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.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have severe and disabling lower extremity symptoms, extreme progression of symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion and a failure of conservative treatment. Official Disability Guidelines state preoperative surgical indications for a spinal fusion include identification and treatment of all pain generators, completion of all physical medicine and manual therapy interventions, documented spinal instability on x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. As per the documentation submitted, the patient has been previously treated with conservative therapy including physical therapy, transforaminal injections and facet joint blocks. The patient continues to report persistent lower back pain. Physical examination does not reveal a significant musculoskeletal or neurological deficit. There were no official imaging studies provided for this review. There is also no documentation of a psychosocial screening. Based on the clinical information received and the above mentioned guidelines, the request is not medically necessary.

**Physical Therapy 2 x week for 6 weeks for the Lumbar Spine and or Sacral Spine:** 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 Brace and Orthofix for Purchase for Lumbar and or Sacral Spine:** 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.

**Cold Therapy Vacutherm Unit for Purchase for the Lumbar and or Sacral Spine:** 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.