

<b>Case Number:</b>	CM14-0039289		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	07/04/2009
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2014

### 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 57-year-old female who reported an injury on 07/04/2009. The mechanism of injury involved a fall. The current diagnoses include obesity, chronic pain, right L1-2 inferiorly migrated intervertebral disc herniation, L3-5 stenosis with claudication, and bowel urgency. The injured worker was evaluated on 01/14/2014 with complaints of persistent lower back pain. A surgical history includes a left carpal tunnel release. The current medications include Motrin. Physical examination on that date revealed painful range of motion, negative straight leg raising, an antalgic gait, diminished lower extremity reflexes, and intact sensation. Treatment recommendations at that time included a bilateral L3-5 laminectomy with medial facetectomy and possible fusion with instrumentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Laminectomies with medial facetectomy with possible discectomy and fusion instrumentation, bilaterally at L3-5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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:** California MTUS/ACOEM Practice Guidelines state a referral for 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 electrophysiologic evidence of a lesion, and a failure of conservative treatment. Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and completion of a psychosocial screening. As per the documentation submitted, there is no evidence of an exhaustion of conservative treatment prior to the request for a surgical intervention. There was no imaging studies provided for review. There is no documented spinal instability on flexion and extension view radiographs. There is no evidence of the completion of a psychosocial screening prior to the request for a lumbar fusion. Based on the clinical information received and the above-mentioned guidelines, the request is not medically necessary.

**Pre-operative Clearance: Lab work - CBC, PT, PTT, Urine, Chem 12:** 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.

**Back Brace Purchase:** 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.