

<b>Case Number:</b>	CM14-0050606		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	12/07/2006
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2014

### 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 58 year old male who sustained an injury on 12/07/06. No specific mechanism of injury was noted. The injured worker was followed for complaints of low back pain radiation to right lower extremity. Prior treatment included selective nerve root blocks in 2013. The injured worker utilized medications including Tylenol with codeine and soma and Prilosec. The injured worker had a prior discography report on 09/30/09 from L2 through S1. The report was difficult to interpret due to copy quality but it appeared that the injured worker had concordant pain at multiple levels. MRI of the lumbar spine on 05/06/13 noted large disc extrusion measuring 8mm at L2-3 contributing to right lateral recess and right neural foraminal stenosis with anterior impingement of the thecal sac. There was degenerative disc disease at L3-4 and L4-5 with 5mm disc bulge contributing to moderate canal stenosis and mild to moderate facet hypertrophy and moderate neural foraminal stenosis at both levels. Only mild facet degenerative changes at L5-S1 was noted. Clinical record from 01/17/14 noted the injured worker had persistent complaints of low back pain radiating to the right foot. There was antalgic gait on physical examination with evidence of weakness while performing heel or toe walking. Limited lumbar range of motion was noted with absent reflexes at the right ankle compared to the left side. There was very minor weakness noted trace at the hip at the left hip. Straight leg raise was negative for findings. There was two beats of clonus in the left foot. Radiographs reportedly showed degenerative scoliosis with apex at L3 and anterior listhesis at L3-4. The recommendation was for L2 to L5 bilateral laminotomies followed by posterolateral instrumentation and fusion from T10 to L5. The requested surgical procedures with post-operative DME physical therapy and pre-operative medical clearance and radiographs were denied by utilization review on 02/20/14.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior lumbar interbody fusion at L2 to L5. Bilateral laminectomies at the L2-L3, L3-L4, L4-L5, with posterior spinal instrumentation fusion T10 to L5.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The requested anterior lumbar interbody fusion from L2 to L5 followed by bilateral laminectomy from L2 to L5 and posterolateral spinal fusion with instrumentation from T10 to L5 would not be supported as medically necessary based on clinical documentation submitted for review and current evidence based guidelines. MRI noted multilevel degenerative disc disease primarily from L2 to L5 contributing to neural foraminal stenosis however the study which is now more than one year old did not identify evidence of thoracolumbar scoliosis or significant kyphosis to warrant the extensive fusion request. Furthermore the clinical documentation submitted did not include pre-operative psychological evaluation ruling out any confounding issues that could possibly impact post-operative recovery as recommended by guidelines. Therefore this reviewer would not have recommended this surgical request as medically necessary.

**LSO Brace:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Low Back Chapter, Back Brace, Post-operative.

**Decision rationale:** In regards to the requested DME this reviewer would not have recommended this request as medically necessary. Surgical request was not felt to be medically indicated therefore there would be no requirement for post-operative DME at this time.

**Bone Growth Stimulator:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Low Back Chapter, bone growth stimulator.

**Decision rationale:** In regards to the requested DME this reviewer would not have recommended this request as medically necessary. Surgical request was not felt to be medically indicated therefore there would be no requirement for post-operative DME at this time.

**Pneumatic Compression Device: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Knee & Leg Chapter, Vasopneumatic device.

**Decision rationale:** In regards to the requested DME this reviewer would not have recommended this request as medically necessary. Surgical request was not felt to be medically indicated therefore there would be no requirement for post-operative DME at this time

**Post-op Physical Therapy 3 times a week for 6 weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

**Decision rationale:** In regards to the request for post-operative physical therapy for 18 sessions the surgical request was not felt to be medically indicated. Therefore there would be no requirement for post-operative physical therapy and the request is not medically necessary.

**Pre-op Medical Clearance with Internal Medicine: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Low Back Chapter, Pre-operative testing, General.

**Decision rationale:** In regards to the request for pre-operative medical clearance with internal medicine the surgical request was not felt to be medically indicated. Therefore there would be no requirement for any pre-operative assessments and the request would not be medically necessary

**X-rays: Pre-op chest x-ray, pre-op lumbar spine AP, lateral, flexion, extension: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Low Back Chapter, Pre-operative testing, general.

**Decision rationale:** In regards to the request for pre-operative radiographs of the chest and lumbar spine, the surgical request was not felt to be medically indicated. Therefore there would be no requirement for any pre-operative radiographs and the request would not be medically necessary.