

<b>Case Number:</b>	CM14-0059736		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	01/31/2013
<b>Decision Date:</b>	12/22/2014	<b>UR Denial Date:</b>	04/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2014

### 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 Spine Surgeon 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 38-year-old female with a reported date of injury of 01/31/2013. The mechanism of injury was not specifically stated. The current diagnoses include lumbago and cervicalgia. The latest physician progress report submitted for this review is documented on 08/05/2014. The injured worker presented with complaints of persistent cervical pain with radiation into the bilateral upper extremities and associated headaches. Previous conservative treatment is noted to include epidural steroid injection, medication management, physical therapy, and chiropractic treatment. The injured worker also reported constant pain in the lower back with radiation into the bilateral lower extremities. Physical examination of the lumbar spine revealed paravertebral muscle tenderness and spasm, positive seated nerve root test, guarded and restricted range of motion, intact coordination and balance, tingling and numbness in the lateral thigh and anterolateral leg, and diminished EHL and ankle strength. Treatment recommendations at that time included authorization for psychological clearance for surgery. The injured worker was also pending authorization for a course of physical therapy. It is noted that the injured worker underwent an MRI of the lumbar spine on 12/30/2013, which revealed a 30% decrease in disc height at L4-5, with a 3 mm posterior disc bulge causing encroachment on the foramina, with compromise of the exiting nerve roots bilaterally. The injured worker also underwent electrodiagnostic studies on 07/11/2013, which revealed no evidence of acute cervical or lumbar radiculopathy. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral L4 - L5 posterior lumbar interbody fusion with instrumentation, neural decompression, and iliac crest marrow aspiration/harvesting, possible junctional levels.:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (spinal).

**Decision rationale:** The CA MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be 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 failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the 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 a psychosocial screening. There was no documentation of spinal instability upon flexion and extension view radiographs. The injured worker is also pending a course of physical therapy as well as a psychosocial screening. Therefore, the current request is not medically appropriate at this time.

**Associated surgical service: Front wheel walker 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.

**Associated surgical service: Ice unit 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.

**Associated surgical service: Bone stimulator 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.

**Associated surgical service: TLSO (Thoracolumbosacral orthosis) 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.

**Associated surgical service: 3-1 commode 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.

**Associated surgical service: Inpatient stay 2-3 days: 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.

**Associated surgical service: Surgery assistant: 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.

**Associated surgical service: Medical clearance:** 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.