

<b>Case Number:</b>	CM14-0069195		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	12/05/2011
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	05/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2014

### 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 51-year-old male who reported an injury on 12/05/2011 after being hit by a car. The injured worker reportedly sustained an injury to multiple body parts to include the knee, low back, cervical spine, and hip. The injured worker's treatment history included physical therapy, chiropractic care, medications, and epidural steroid injections. The injured worker was evaluated on 04/17/2014. It was documented that the injured worker had 10/10 pain. Physical findings included severely limited range of motion with a positive straight leg raising test bilaterally. It was noted that the injured worker had previously undergone an EMG that documented L5-S1 radiculopathy, an MRI that documented L5-S1 foraminal stenosis, and an x-ray that documented instability with flexion and extension at the L5 on the S1. The injured worker's treatment plan included post lateral interbody fusion at the L5-S1. A Request for Authorization Form dated 07/24/2014 was submitted to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Laminectomy posterior spinal fusion with instrumentation posterior lateral interbody fusion L5-S1:** 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): 307.

**Decision rationale:** The requested laminectomy posterior spinal fusion with instrumentation and posterolateral interbody fusion at the L5-S1 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend fusion surgery for patients who have evidence of instability. The clinical documentation submitted for review does indicate that the injured worker has an x-ray that documents evidence of instability. However, the American College of Occupational and Environmental Medicine also recommends a psychological evaluation prior to spinal surgery. The clinical documentation submitted for review failed to provide any evidence of a psychological evaluation to determine that the injured worker has no complicating factors to delay recovery following a fusion surgery. As such, the requested laminectomy posterior spinal fusion with instrumentation posterolateral interbody fusion at L5-S1 is not medically necessary or appropriate.

**Assistant Surgeon:** 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.

**5 day inpatient stay:** 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.

**Norco (frequency, duration and quantity unspecified):** 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.

**Voltaren (frequency, duration and quantity unspecified):** 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.

**Flexeril (frequency, duration and quantity unspecified):** 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.

**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.

**Front wheeled 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.

**Custom molded thoracolumbosacral orthosis (TLSO) brace:** 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.

**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.