

<b>Case Number:</b>	CM14-0078964		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	02/19/2009
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	05/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2014

### 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 Neurological 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 56-year-old male who was reportedly injured on 2/19/2009. The mechanism of injury was not known because the injured worker was knocked unconscious after he opened the rear door of his tractor trailer and pallets of freight fell on top of him. The injured worker underwent a lumbar microdiscectomy at L4-5 on 8/1/2013. The most recent progress note dated 5/8/2014, indicated that there were ongoing complaints of low back pain that radiated to the right lower extremity. The physical examination demonstrated low back incision healed without signs of infection; tenderness to the spinous processes, right facet joint, paraspinal musculature and left sacroiliac joint. There was limited lumbar spine range of motion and pain with extension. Lower extremity strength with right hip flexion 4/5, otherwise 5/5 bilaterally. There was also positive right straight leg raise on the right and tight, mildly positive on the left. Positive left Flexion, Abduction, and External Rotation sign. Sensation diminished with pinprick left lateral leg. Knee and ankle reflexes 2 bilaterally. No clonus. Positive Romberg's test. Ambulation was with a limp and required a cane. Computed tomography myelogram of the lumbar spine, dated 8/31/2011, demonstrated right foraminal narrowing at L3-4, L5 pars fracture and disk protrusions at L4-5 and L5-S1. An MRI of the lumbar spine, dated 4/10/2014, showed a recurrent disk protrusion at L4-5 with foraminal narrowing, lumbar spondylosis and congenital stenosis. The previous treatment included lumbar microdiscectomy, multiple lumbar injections and medications to include Norco 10/325 mg, Soma 350 mg and gabapentin 600 mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L3-S1 definitive stabilization surgery.:** 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.

**Decision rationale:** The ACOEM practice guidelines do not support a spinal fusion in the absence of an unstable fracture, dislocation, spondylolisthesis, instability or evidence of tumor/infection. The review of the available medical records documented a diagnoses of lumbar radiculopathy and a recurrent disk protrusion at L4-5 but failed to document spondylolisthesis, instability or abnormal motion with flexion/extension plain radiographs. Given the lack of documentation, this request is not considered medically necessary.

**Preop clearance.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.guideline.gov/content.aspx?id=38298>.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Lumbar bracing .:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low back.

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

**Decision rationale:** The ACOEM treatment guidelines do not support the use of a lumbar sacral orthosis (lumbar/back brace) for the treatment or prevention of low back pain, except in cases of specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The injured worker is currently not in an acute postoperative setting, and there was no documentation of instability or spondylolisthesis. As such, this request is not considered medically necessary.