

<b>Case Number:</b>	CM14-0083118		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	08/23/2010
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2014

### 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 New York. 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:

This patient is a 55-year-old male with a date of injury of September 16, 1995. The patient has chronic low back pain. The patient had a laminectomy in November 2013. He only had temporary relief from the laminectomy. Physical examination reveals decreased sensation throughout the bilateral lower extremities. There is burning-type sensation left L3-4 distributions. Straight leg raise is positive. A CT myelogram shows moderate disc space height loss and endplate changes at L1-2. There is moderate canal stenosis. At issue is whether L1 to discectomy and fusion a medically needed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **L1-L2 Transforaminal Discectomy and Fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-306. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter.

**Decision rationale:** This patient does not meet established criteria for lumbar decompression or fusion. Specifically there is no documentation of lumbar instability, fracture, or tumor. There is

also no correlation between the patient's imaging studies showing specific compression of nerve roots and physical exam showing specific radiculopathy. Established criteria for both lumbar decompression and fusion are not met. As such, the request is not medically necessary and appropriate.

**Inpatient Stay:**

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

**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.

**LSO Back Brace:**

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

**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.