

<b>Case Number:</b>	CM14-0169413		
<b>Date Assigned:</b>	10/17/2014	<b>Date of Injury:</b>	12/10/2000
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	09/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2014

### 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 Surgeon, has a subspecialty in Spine Surgeon and is licensed to practice in New Jersey. 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 51-year-old male who reported an injury on 12/10/2000 due to an unspecified mechanism of injury. On 08/26/2014, he reported chronic low back pain with bilateral low back pain described as constant and sharp. He also reported pain that radiated up towards the neck and lower extremity pain with moderate spasm. He rated his pain at an 8/10 to 9/10. A physical examination showed that he walked on his heels and toes without difficulty and there was paralumbar spasm with 2+ tenderness to palpation on the left. Atrophy was present in the quadriceps. On forward flexion, the injured worker was able to reach to the knees; lateral bending to the right was to 0 to 10 degrees and to the left was 20 to 30 degrees with pain; extension measured 0 to 10 degrees; right resisted rotation was diminished and left resisted rotation was diminished. The straight leg raise was positive on the left. Range of motion was limited secondary to pain in the lumbar spine. Lower extremity deep tendon reflexes were absent at the knees. Sensation was decreased in the left lateral thigh. Motor strength of the lower extremities measured 5/5 in all groups. An unofficial MRI of the lumbar spine, performed on an unspecified date, reportedly showed left sided bulging at the L5-S1. He was diagnosed with low back pain, lumbar disc displacement, lumbar radiculopathy, and spasm of the muscle. Information regarding the injured worker's medications and surgical history was not provided for review. The treatment plan was for an L5-S1 posterior lumbar interbody fusion (PLIF) with instrumentation and attempt at reduction of listhesis and realignment of junctional kyphotic deformity back to lordosis with an assistant surgeon, 2 to 3 days inpatient stay, decision for an ice unit purchase, and a 3 in 1 commode purchase. The Request for Authorization and rationale for treatment were not provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 Posterior Lumbar Interbody Fusion (PLIF) with Instrumentation and Attempt at Reduction of Listhesis and Realignment of Junctional Kyphotic Deformity Back to Lordosis with an assistant surgeon: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary last updated 08/22/2014

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion

**Decision rationale:** The request for an L5-S1 posterior lumbar interbody fusion (PLIF) with instrumentation and attempt at reduction of listhesis and realignment of junctional kyphotic deformity back to lordosis with an assistant surgeon is not medically necessary. The California MTUS/ACOEM Guidelines state that those with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for a fusion. The Official Disability Guidelines state that fusions are not recommended until the injured worker has failed at least 6 months of recommended conservative care. There should also be evidence of instability on imaging studies and evidence that there has been a psychosocial evaluation. The Official Disability Guidelines additionally state that assistant surgeons are recommended for more complex surgeries. Based on the clinical information submitted for review, the injured worker was noted to be symptomatic regarding the lumbar spine. However, there was no documentation showing that he had undergone a psychological evaluation to support the request for a fusion. There was also no documentation showing that the injured worker had failed at least 6 months of recommended conservative care and official imaging studies were not provided to validate that there is instability. In the absence of this information, the request would not be supported by the evidence based guidelines. Given the above, the request is not medically necessary.

**2 to 3 day inpatient stay: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary last updated 08/22/2014

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Hospital Length of Stay

**Decision rationale:** The request for 2 to 3 days inpatient stay is not medically necessary. The CA MTUS/ACOEM Guidelines do not address the request. The Official Disability Guidelines state that average hospital length of stay following a fusion is 3 days. While the requested length of stay is within the guideline recommendations, the concurrent request for a lumbar fusion was

not supported by the provided documentation. Without the surgical intervention being duly authorized, the request for an inpatient stay in the hospital would not be supported. Given the above, the request is not medically necessary.

**Ice unit purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cryotherapy

**Decision rationale:** The request for an ice unit purchase is not medically necessary. The CA MTUS/ACOEM guidelines do not address this topic. The Official Disability Guidelines state that heat and cold packs are recommended as an option for acute pain. The rationale for a purchase of this equipment rather than a rental was not stated and would not be supported. Without this information, the request would not be supported by the evidence based guidelines. Given the above, the request is not medically necessary.

**3 in 1 commode purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Knee and Leg Procedure Summary last updated 01/09/2013

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, DME

**Decision rationale:** The request for a 3 in 1 commode purchase is not medically necessary. The CA MTUS/ACOEM Guidelines do not address the request. The Official Disability Guidelines state that durable medical equipment is primarily and customarily used to serve a medical purpose and can normally be rented and used in a person's home. Durable medical equipment is only recommended for rental by the guidelines. Therefore, the request for a purchase of a 3 in 1 commode would not be supported. In addition, a clear rationale for the medical necessity of a 3 in 1 commode was not stated. Given the above, the request is not medically necessary.