

<b>Case Number:</b>	CM14-0200313		
<b>Date Assigned:</b>	12/10/2014	<b>Date of Injury:</b>	06/29/2006
<b>Decision Date:</b>	01/27/2015	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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 Georgia and South Carolina. 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 70-year-old male who reported an injury on 06/29/2006. The mechanism of injury was due to lifting a heavy box. The injured worker has a diagnosis of degeneration lumbar intervertebral disc, lumbar stenosis, postlaminectomy syndrome of the lumbar region, radiculopathy, and weakness of the muscles. The injured worker underwent lumbar spine surgery in 03/2010. There was no documentation of past conservative treatment. MRI of the lumbar spine that was obtained on 08/28/2014 indicated multilevel degenerative changes, advanced facet arthropathy, and neural foraminal stenosis at L3-4 level. No central canal stenosis. There was also notation of minor mid lumbar levoscoliosis; alignment otherwise generally preserved, no focal OCS abnormality. EMG/NCS of the bilateral lower extremities revealed prolonged bilateral tibial H-reflex latencies; may be indicative of a possible bilateral S1 sacral radiculopathy versus early peripheral neuropathy (given borderline conduction velocities in the bilateral lower extremity motor nerves and borderline latencies of bilateral lower extremity sensory nerves). There was no electro diagnostic evidence of peripheral nerve entrapment neuropathy. 09/08/2014, the injured worker complained of low back pain. He stated that he had sensation in the legs that caused him to lose balance, had increasing urinary control problems, dribbling, and stress incontinence. He also had bowel control problems. He was noted to have numbness in the thighs and pain in the knee regions. Physical examination of the back revealed normal contour. He was nontender to palpation throughout. Lateral bending was 10 to 20 degrees with pain. Extension was 10 to 20 degrees with mild pain. On forward flexion, the injured worker was able to reach ankles. Gait heel and toe walking was normal. Motor strength was 5/5 in all groups bilaterally. Sensation to light touch was decreased on the right lateral thigh. Reflexes were equal bilaterally. There was a negative straight leg raise, clonus, and toes down going bilaterally. Medical treatment plan is for the injured worker to undergo lateral

interbody fusion at L3-5, transforaminal lumbar interbody fusion at L5-S1, laminectomy, posterior fusion L2-S1 of the lumbar spine. Provider feels that surgery is necessary due to ongoing back symptoms. Request for Authorization form was not submitted for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Lateral interbody fusion L2-5, transforaminal lumbar interbody fusion L5-S1, laminectomy, posterior fusion L2-S1 for the lumbar: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**Decision rationale:** The request for lateral interbody fusion L2-5, transforaminal lumbar interbody fusion L5-S1, laminectomy, posterior fusion L2-S1 for the lumbar spine is not medically necessary. California MTUS/ACOEM Guidelines do not recommend spinal fusion, except in cases of trauma related spinal fracture or dislocation, fusion of the spine is not usually considered during the first 3 months of symptoms. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. Criteria for surgical consideration consists of severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies; activity limitations due to radiating leg pain for more than 1 month or extreme progression of lower leg symptoms; clear clinical, imaging, and electro physiologic evidence of a lesion that has been shown to benefit from surgical repair; and failure of conservative treatment to resolve disabling radicular symptoms; and/or psychological screening to improve surgical outcomes. The submitted documentation indicated that the injured worker complained of moderate to severe pain in his back, legs, feet, hands, arms, shoulder, and neck. However, there was no indication of the injured worker having any activity limitations due to the radiating pain. Additionally, there was no indication of the injured worker having trialed and failed conservative treatment. Furthermore, there was no documentation of the injured worker having undergone psychological screening. Given the above, the injured worker is not within MTUS/ACOEM recommended guideline criteria. As such, the request for lateral interbody fusion L2-5, transforaminal lumbar interbody fusion L5-S1, laminectomy, posterior fusion L2-S1 for the lumbar is not medically necessary.

**Associated surgical service: 2-3 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.

**Associated surgical service: bone growth stimulator for lumbar:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2014, Low Back chapter

**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: 2 week rental of motorized cold therapy unit for post-operative use for lumbar:** 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: LSO brace purchase for post-operative use for lumbar:** 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: post-operative therapy 12 visits over 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 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.