

<b>Case Number:</b>	CM14-0219198		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	11/04/2012
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	12/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 32-year-old male who reported a repetitive strain injury on 11/04/2012. The current diagnosis is unstable spine at L5-S1 with motor and sensory deficits in the L5 distribution. The injured worker presented on 11/14/2014 for a followup orthopedic consultation. It was noted that the injured worker ambulated with a cane for assistance. Upon examination, there were no new motor or sensory deficits noted. There was 20 degree flexion, extension, and lateral rotation. There was an abnormal heel to toe gait with reciprocation remarkable for imbalance. Recommendations included surgical intervention for the lumbar spine. A Request for Authorization form was submitted on 11/24/2014 for a lumbar decompression with fusion at L5-S1. It was noted that the injured worker underwent flexion and extension view x-rays of the lumbar spine on 06/13/2013, which revealed no radiographic evidence of acute fracture or vertebral instability. The injured worker also underwent an MRI of the lumbar spine on 05/22/2013, which revealed evidence of listhesis of L5 on S1, with moderate facet arthropathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Decompression including Laminectomy, Disectomy, Facetomy. Foraminotomy at L5-S1, Fusion with Iliac Crest, Graft & Instruments including cages and pedicle screws:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG, Low Back and ACOEM Guidelines (revised 2007), Low Back Disorders, page(s) 209-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (spinal).

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines state preoperative surgical indications for a spinal fusion should include the identification and treatment of all pain generators, the completion of all physical medicine and manual therapy interventions, documented instability upon x-ray or CT myelogram, spine pathology that is limited to 2 levels, and a psychosocial screening. In this case, there was no objective evidence of a significant musculoskeletal or neurological deficit consistent with imaging findings. There was also no mention of a recent attempt at conservative management. There was no documentation of a psychosocial screening prior to the request for a lumbar fusion. Given the above, the request is not medically appropriate in this case.

**Associated Surgical Service: Inpatient Stay (2-3 days):** 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 not medically necessary.

**Associated Surgical Service: Medical Clearance (EKG & labs):** 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 not medically necessary.

**Associated Surgical Service: Chest x-ray:** 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 not medically necessary.

**Associated Surgical Service: Lumbar x-ray:** 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 not medically necessary.

**Associated Surgical Service: MRI Lumbar Spine:** 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 not medically necessary.

**Associated Surgical Service: Intraoperative Monitoring Service, SSEP, EMG:** 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 not medically necessary.

**Associated Surgical Service: Cell Saver:** 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 not medically necessary.

**Associated Surgical Service: Assistant for 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 not medically necessary.

**Associated Surgical Service: Cold Therapy Unit (7-day rental):** 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 not medically necessary.

**Associated Surgical Service: Bone Stim (purchase):** 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 not medically necessary.

**Associated Surgical Service: Back Brace (purchase):** 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 not medically necessary.

**Associated Surgical Service: 3-in-1 Commode (purchase):** 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 not medically necessary.

**Associated Surgical Service: Shower Chair (purchase): 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 not medically necessary.

**Post-Operative Physical Therapy (8 sessions, 2 times per week for 4 weeks): 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 not medically necessary.