

<b>Case Number:</b>	CM15-0004657		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	12/11/2010
<b>Decision Date:</b>	04/21/2015	<b>UR Denial Date:</b>	12/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2015

### 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: Oregon, California  
 Certification(s)/Specialty: Neurological Surgery

### 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 52-year-old female who reported an injury on 12/11/2010. The mechanism of injury was not specifically stated. The current diagnoses include status post C4-C7 hybrid reconstruction, retained symptomatic cervical spine hardware, right shoulder impingement syndrome, and lumbar discopathy with evidence of instability. The injured worker presented on 11/03/2014, for a followup evaluation regarding chronic low back pain. The injured worker reported persistent low back pain with radiation into the bilateral lower extremities. The provider indicated that the patient had multilevel lumbar spondylosis and instability from L3 to S1. However, there was no documentation of flexion and extension view x-rays to corroborate the diagnosis. Upon examination of the lumbar spine, there was paravertebral muscle tenderness with spasm, a positive seated nerve root test, guarding with restricted range of motion, tingling and numbness in the lower extremity in the L4 dermatomal pattern, and diminished motor strength. Recommendations at that time included an L3-S1 posterior lumbar interbody fusion. A Request for Authorization form was not submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L3-S1 Post lumbar interbody infusion with instrumentation and attempt at reduction of listhesis with realignment of junctional kyphotic deformity, at level of L5-S1, removal of synovial cyst at L4-L5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 306-307. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**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, it is noted that the injured worker has exhausted conservative treatment. However, there was no documentation of a psychosocial screening completed prior to the request for a lumbar interbody fusion. The provider indicated there was evidence of lumbar instability. However, there was no documentation of flexion/extension view x-rays. Given the above, the request is not medically appropriate at this time.

**2-3 Days inpatient hospital 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 services) Medical clearance with an internist:** 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 services) Front wheel walker: 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 services) Ice Unit: 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 services) Bone stimulator: 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 services) Thoracic-Lumbo-Sacral-Orthosis (TLSO): 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 services) 3-in-1 Commode: 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.

**Assistant 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 medically necessary.