

<b>Case Number:</b>	CM15-0108784		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	11/16/2011
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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: New York

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 55 year old male who sustained an industrial injury on 11/16/2011. Treatment provided to date has included: physical therapy, hernia repair surgery (11/09/2012), medications, and conservative therapies/care. Diagnostic tests performed include: MRI of the lumbar spine (09/09/2014) showing a 4-5mm broad posterior disc protrusion at L4-5 with moderate facet arthropathy resulting in mild to moderate right neural foraminal narrowing, and mild to moderate facet arthropathy at L4-5 and L5-S1. Comorbid diagnoses included history of diabetes type II uncontrolled, hypertension, hyperlipidemia, and vitamin D deficiency. There were no noted previous injuries or dates of injury. On 03/24/2015, the secondary treating physician's progress report noted complaints of occipital headaches (rated 6/10), pain in the eyes (rated 4/10), low back pain (rated 7/10), pain in foot (rated 8/10) and ankle pain (rated 5/10). The injured worker's pain was associated with numbness in the left foot and swelling in the left ankle. Pain was noted to radiate to the left ankle and foot. Walking and sitting was noted to aggravate the symptoms. The injured worker's medications were not listed, but it was noted that the injured worker is taking increased amounts of medications due to worsening pain. The physical exam was unchanged from the previous exam findings. The provider noted diagnoses of degenerative disc disease, disc protrusion, radiculopathy and stenosis at L4-L5, and left lower extremity radiculopathy. Due to increasing pain, the injured worker agrees to the plan for surgical intervention. Plan of care includes an L4-5 anterior/posterior discectomy, decompression and fusion with instrumentation, allograft and bone morphogenic protein, pre-operative medical clearance, a cold therapy unit, post-operative lumbar brace, 12 sessions of post-operative

physical therapy and a post-operative bone growth stimulator. The injured worker's work status is modified/ restricted. Requested treatments include an L4-5 anterior/posterior discectomy, decompression and fusion with instrumentation, allograft and bone morphogenic protein, pre-operative medical clearance, a cold therapy unit, post-operative lumbar brace, 12 sessions of post-operative physical therapy and a post-operative bone growth stimulator.

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

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

#### **L4-L5 anterior/posterior discectomy, decompression and fusion with instrumentation, allograft and bone morphogenic protein: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306, 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter and on the Non-MTUS AMA Guides, pages 379, 382-383.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: L4-L5 anterior/posterior discectomy, decompression and fusion with instrumentation, allograft and bone morphogenic protein is not medically necessary and appropriate.

#### **Associated surgical service: Cold Therapy 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.

#### **Post-operative bone growth 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.

**Post-operative lumbar spine brace: 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: Physical therapy 3x4: 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.

**Pre-operative Medical Clearance: 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.