

<b>Case Number:</b>	CM15-0195475		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	03/04/2013
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	09/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2015

### 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, Montana, 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 29 year old female, who sustained an industrial injury on 3-4-13. The injured worker was diagnosed as having failed back surgery-lumbar; lumbar disc degeneration; lumbar disc herniation; lumbar pain. Treatment to date has included lumbar epidural steroid injections (4-2013); status post lumbar laminectomy (6-2013); status post lumbar microdiscectomy left posterior partial laminectomy L4-5 (2-2-15); physical therapy; medications. Diagnostics studies included EMG-NCV lower extremities (4-20-15); MRI lumbar spine (7-16-15). Currently, the PR-2 notes dated 8-10-15 indicated the injured worker complains of pain. The PR-2 is in regards to an H-wave indicating the injured worker has trialed one at home between 6-8-15 to 7-29-15. The provider documents "Patient has reported the ability to perform more activity and greater overall function due to the use of the H-Wave device. Patient has given examples of increased function due to H-Wave: 'More housework; more family interaction; helps with mobility.' Patient also made these comments 'Unit is a miracle worker.' The patient is utilizing the home H-Wave 2 times per day, 7 days per week; 45+ minutes per sessions. Other treatments used prior to H-Wave: TENS unit, physical therapy, medications, home exercise." The provider notes the injured worker has not sufficiently improved with conservative care. This modality is recognized as a treatment option. A MRI of the lumbar spine dated 7-16-15 impression reveals "1) the patient is a status post microdiscectomy through a left posterior partial laminectomy at L4-L5. There is degenerative disc disease with reactive endplate changes and a disc protrusion that is small in size. It is touching the thecal sac but does not appear to be displacing the intracranial nerve roots. It is contributing to a mild to moderate canal stenosis.

The neural foramen is normal. 2) There is significant degenerative disc disease with a small broad-based posterior disc protrusion that does not appear to be displacing the intracranial nerve roots. The patient is status post left posterior laminectomy and partial discectomy. There are mild bilateral neural foraminal stenosis with a mild canal stenosis. 3) At the L3-L4 level there is a mild canal stenosis secondary to ligamentum flavum hypertrophy and facet disease." An EMG-NCV study of the lower extremities dated 4-20-15 concluded, "Putting the EMG and NCS together, the only real abnormality is the marked decreased amplitude of the CMAP of the left peroneal nerve and the borderline increase of the left H-reflex compared to the right. These are suggestive of a chronic left L5 or S1 radiculopathy. She has damaged some of the fibers from the left peroneal nerve while the fastest fibers remain to give a normal conduction velocity and F-wave, but enough fibers have dropped out to decrease the amplitude of the CMAP. There is no evidence for active radiculopathy, only chronic." The only other medical documentation submitted are physical therapy notes of 16 visits and an "Initial Orthopedic Consultation - AME with review of outside records" dated 4-20-15 for 95 pages. A Request for Authorization is dated 10-6-15. A Utilization Review letter is dated 9-24-15 and non-certification for Lumbar fusion at L3-4, L4-5, L5-S1 and associated services. However, Utilization Review modified the certification to allow the requested associated service for a psychological evaluation.

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

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

#### **Lumbar fusion at L3-4, L4-5, L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of this. His magnetic resonance imaging scan (MRI) of 7/16/15 showed no severe canal or foraminal stenosis or nerve root impingement. His provider recommended a lumbar arthrodesis L3-S1 to treat his lumbago. Documentation does not present evidence of instability or radiculopathy. According to the Guidelines for the performance of fusion procedures for degenerative diseases of the lumbar spine, published by the joint section of the American Association of Neurological surgeons and Congress of Neurological surgeons in 2005 there was no convincing medical evidence to support the routine use of lumbar fusion at the time of primary lumbar disc excision. This recommendation was not changed in the update of 2014. The update did note that fusion might be an option if there is evidence of spinal instability, chronic low back pain and severe degenerative changes. Documentation does not show instability or severe degenerative changes. The requested Treatment: Lumbar fusion at L3-4, L4-5, L5-S1 is not medically necessary and appropriate.

**Pre-operative workup- 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 medically necessary.

**Pre-operative workup- EKG: 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 workup- UA: 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 workup-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 medically necessary.

**Post-operative cold therapy unit with pad: 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: Crutches:** 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: Continue physical therapy 2x4 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.

**Pre-operative psychological evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological evaluations.

**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.