

<b>Case Number:</b>	CM15-0021733		
<b>Date Assigned:</b>	02/11/2015	<b>Date of Injury:</b>	10/13/2012
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	01/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2015

### 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: Texas  
 Certification(s)/Specialty: Orthopedic 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 50-year-old female who reported an injury on 10/13/2011 and the mechanism of injury was not provided. The injured worker's diagnoses include chronic lumbosacral strain, superimposed on degenerative disc disease with multiple injuries and previous surgery, with extension residuals, but minimal evidence or complaints of radiculopathy. The previous medical treatment includes therapy, medications and several spinal injections without resolution of her symptoms. The only noted documentation of a previous diagnostic study was in 2012 the injured worker had a CT performed. The injured worker had previous low back surgery in 2003. The injured worker complains of severe low back pain that radiates down the legs to the back of her hamstrings to about the knee level. She noted that the right leg is worse than the left leg. The physical exam notes that the injured worker has a 1-inch incisional scar that is well healed; she has tenderness to palpation over the incisional scar area L4-5. The range of motion was 30 degrees at flexion, extension was 10 degrees, left lateral bending was 25 degrees and right lateral bending was 25 degrees. There was a positive straight leg raise that indicates low back pain that radiates down to the right leg with the right leg elevated to about 45 degrees from the supine position. There was 0/5 Waddell's sign and a negative Faber's sign. There was 5/5 strength and normal sensation as well as 2+ reflexes. There is a history of hypertension for which she would need appropriate medical clearance and lab work for any surgical treatments. The injured worker's medications include Nexium, Celebrex, Atenolol, and Motrin. Treatment plan was for lumbar surgery. There was no Request for Authorization provided.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**ALIF L4-5 with open reduction, PSF/I L4-5 with Open Reduction with [REDACTED], [REDACTED], Co-Surgeon, Assistant Surgeon, and Inpatient Hospital Stay (2-days): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Spinal Fusion, Surgical assistant, Hospital length of stay (LOS).

**Decision rationale:** The request is not supported. The injured worker has a decreased range of motion in flexion and extension. There was a straight leg raise positive for low back pain that radiates down to the right leg with the right leg elevated at 45 degrees. There was 5/5 hip flexion, hip abduction, hip adduction, knee extension, hamstrings, EHL, tibialis anterior motor strength. There was normal sensation to light touch and the reflexes are 2+. The injured worker had a grade 1 anterolisthesis of the L4 on L5, which is most apparent on flexion. The Official Disability Guidelines recommend spinal fusion after all pain generators are identified and treated as well as all physical medicine and manual therapy interventions are completed. There needs to be x-rays demonstrating spinal instability as well as an MRI demonstrating disc pathology correlated with symptoms and exam findings. Spine pathology needs to be limited to 2 levels. There needs to be a psychosocial screen with confounding issues addressed. There is no documentation provided that the injured worker has had an MRI that demonstrates disc pathology that correlates with the symptoms and exam findings. There is also no documentation of the injured worker receiving a psychosocial screen to address confounding issues. The guidelines only recommend a surgical assistant in the more complex surgeries. The surgical procedure CPT code is not 1 of the recommended codes in the Official Disability Guidelines. The guidelines recommend the target length of stay for a spinal fusion is 3 days without complications. The injured worker would be appropriate for a 2-day inpatient hospital stay; however, given the above information, the request for an ALIF L4-5 with open reduction, PSF-I L4-5 with open reduction with [REDACTED], co surgeon, assistant surgeon, x2 day inpatient hospital stay is not medically necessary.

**Pre-Operative Consult with Co-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.

**Medical Clearance Appointment:** 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 Lab Work: CBC, PT, PTT, INR, CMP, UA, EKG, and Chest X-Rays:**  
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.

**Lumbar 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 medically necessary.

**Bone Growth Stimulator (purchase, office fitting):** 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.