

<b>Case Number:</b>	CM15-0042722		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	01/13/2012
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	02/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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: 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 47-year-old male who reported an injury on 01/13/2012. The injury reportedly occurred when the injured worker tried to prevent a heavy rack from falling. He was diagnosed with lumbar spinal stenosis at L3-4 and L4-5 and lumbar degenerative disc disease. His past treatments were noted to include physical therapy and multiple epidural steroid injections. His diagnostic studies included an x-ray of the lumbar spine performed on 06/03/2014, which revealed no significant abnormalities. On 02/03/2015, the injured worker was seen for orthopedic re-evaluation. The injured worker reported low back pain, which he rated 8/10. Upon physical examination of the lumbar spine, he was noted to have tenderness at the paravertebral musculature. Forward flexion was 30 degrees, extension to 10 degrees, lateral bending to 30 degrees. The straight leg raise test was negative bilaterally. The strength in the lower extremities was globally intact. No current medications were provided. The treatment plan included surgical intervention as per the recommendation of a previous physician. A request was submitted for 1 transforaminal lumbar interbody fusion at level L3-5, 1 chest x-ray, 1 urinalysis, 1 electrocardiogram (EKG), 1 medical clearance from internal medicine doctor, 1 prothrombin time (PT), partial thromboplastin (PTT) and complete blood count (CBC); however, the rationale was not provided. A Request for Authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **1 Electrocardiogram (EKG): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Low back - Lumbar & Thoracic.

**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.

### **1 chest X-ray: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Low back - Lumbar & Thoracic.

**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.

### **1 Urinalysis: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Low back - Lumbar & Thoracic.

**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.

### **1 Transforaminal lumbar interbody fusion at Level L3-5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back - Lumbar & thoracic, Indications for surgery.

**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, Fusion (spinal).

**Decision rationale:** The California MTUS/ACOEM state except for cases of trauma related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three

months of symptoms. Patients with increased spinal instability (not work related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. More specifically, 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 and manual therapy interventions, documented instability upon x-ray or CT Myelogram, spine pathology that is limited to two levels, and a psychosocial screening. The clinical documentation indicates the injured worker has had previous lumbar epidural steroid injections and physical therapy; however, there was no evidence of instability on an x-ray. Additionally, there was no evidence that the injured worker had psychological clearance prior to surgical intervention. Furthermore, no official imaging studies were provided for review. Moreover, the most recent clinical documentation submitted for review does not provide evidence of symptoms or exam findings to support the need for a lumbar fusion. Given the above information, the request is not supported by the guidelines. As such, the request for 1 transforaminal lumbar interbody fusion is not medically necessary.

**1 prothrombin time (PT), Partial thromboplastin (PTT) and Complete blood count (CBC):**  
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.

**1 medical clearance from internal medicine doctor:** 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.