

<b>Case Number:</b>	CM15-0056413		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	09/08/2012
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2015

### 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:

This 47 year old female on September 8, 2012 reported severe low back pain with radiating pain to the left buttock, thigh, calf and foot after a folding table fell against a basket cart causing it to hit the patient's tailbone. The lumbar spine MRI scan on 01/14/2013 showed degenerative discs with a 2-3 mm central protrusion at L5-S1. The injured worker was diagnosed as having degeneration of the lumbar/lumbosacral discs, moderate foraminal stenosis of the lumbar spine and left lumbar radiculopathy with chronic and subacute denervation. Physical exam showed markedly reduced range of motion of her back, slow standing with great difficulty from sitting and a forward flexed posture. Treatment to date has included radiographic imaging, diagnostic studies, physical therapy, steroid injections, medications and work restrictions. EMG and NCVs are described as showing on 11/4/2014 a mild left L4/5 radiculopathy with subacute and chronic denervation. Currently, the injured worker complains of severe low back pain with pain radiating into the thigh, buttock, calf and foot. She was treated conservatively without complete resolution of the pain. The PR2 of 01/15/2015 shows the patient is emotionally upset and stated there was absolutely no work she was physically capable of performing. Her gait was described as normal. Evaluation on February 12, 2015, revealed continued severe pain. It was noted the physician did not believe the pain would improve without surgical intervention. The plan included lumbar fusion, post-operative durable medical equipment, medications and a bone stimulator post-operatively.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior lumbar interbody fusion with instrumentation at L3-4, L4-5, and L5-S1 with 3 day inpatient length of stay: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Fusion (spinal) Hospital length of stay.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305 and 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 also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The requested treatment is for an anterior lumbar interbody fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The California MTUS guidelines note the wisdom of psychological assessment. Documentation does not show such assessment but does state the patient is emotionally upset. The requested treatment: Anterior lumbar interbody fusion with instrumentation at L3-4, L4-5, and L5-S1 with 3 day inpatient length of stay is not medically necessary and appropriate.

**Associates Surgical Services: 14 Day rental of a post-operative cold therapy unit with back pad compression for the lumbar spine: 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), Neck, and Continuous-flow cryotherapy.

**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.

**Purchase of post-operative Spinalogic lumbar bone growth stimulator: Upheld**

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

**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.

**Purchase of Post-operative 3-in-1 commode as related to the lumbar spine:** 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), Knee and leg, durable medical equipment (DME).

**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.

**Purchase of Post-operative lumbar Cybetck back brace:** Upheld

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

**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.