

<b>Case Number:</b>	CM15-0058753		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	10/08/2011
<b>Decision Date:</b>	05/26/2015	<b>UR Denial Date:</b>	03/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2015

### 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 male who reported an injury on 10/08/2011. The mechanism of injury was reportedly when he was struck in the chest by cargo pushing him against a steel wall. His diagnoses include degeneration of lumbar or lumbosacral intervertebral disc, displacement of lumbar intervertebral disc without myelopathy, lumbago, and thoracic or lumbosacral neuritis or radiculitis. Past treatments were noted to include medications, epidural steroid injections, and pain management. An MRI was noted to reveal degenerative disc disease to the L4-5 level with a 7 mm left lateral disc protrusion and degenerative disc disease to the L5-S1 level with a 4 mm central and left lateral disc protrusion. An x-ray was performed of the lumbar spine and noted to reveal significant degenerative disc disease at L4-5 and L5-S1. The injured worker underwent a left L4-5 and L5-S1 laminotomy, foraminotomy, discectomy, and decompression to the L4-5 and L5-S1 levels on 06/14/2012. On 02/16/2015, it was noted the injured worker had increasing low back pain, left gluteal pain, and intermittent posterior leg pain to the knee. Upon physical examination, it was noted the injured worker had decreased motor strength to the left lower extremity and hypoactive reflexes to the bilateral lower extremities. He had a positive straight leg raise, left greater than right. His motor strength was intact to the right lower extremity, and his sensation was intact to the bilateral lower extremities. On 03/16/2015, it was noted the injured worker had severe low back pain, left leg pain, and left leg weakness and numbness. Upon physical examination, it was noted the injured worker a positive straight leg raise, absent deep tendon reflexes, and decreased sensation to the left lower extremity. Current medications were not included in the report. The treatment plan was noted to include a lumbar

fusion. A request was received for Lumbar Fusion L4-L5 and L5-S1, Associated Surgical Services: Intraoperative Monitoring Surgery clearance with internist/Assistant Surgeon, Associated Surgical Services: X-rays Lumbar Spine series with flex, ext views, and Associated Surgical Services: LSO Back Brace for recurrent disc changes, back and left leg pain with neurological deficits, and failure of conservative treatment. A Request for Authorization was not provided.

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

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

#### **Lumbar Fusion L4-L5 and L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online Version, Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion (spinal).

**Decision rationale:** According to the California MTUS/ACOEM Guidelines, surgical consideration is indicated for those with severe and disabling lower leg symptoms, activity limitation for more than a month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and failure of conservative treatment. More specifically, the Official Disability Guidelines indicate that preoperative indications recommend a psychological screen, and that all physical medicine and manual therapy interventions have been completed. The clinical documentation submitted for review indicated the injured worker had back and left lower extremity pain with neurological deficits. However, there was no documentation noting instability, a psychological screen, or the failure of physical therapy. Consequently, the request is not supported. As such, the request for Lumbar Fusion L4-L5 and L5-S1 is not medically necessary.

#### **Associated Surgical Services: Intraoperative Monitoring Surgery Clearance with Internist/Assistant 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.

#### **Associated Surgical Services: X-Rays of the Lumbar Spine (series with flex, ext views): 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 Services: LSO Back 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.