

<b>Case Number:</b>	CM14-0124501		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	05/13/2012
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	07/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 is a 49 year old male with a 5/13/12 injury date. He was loading and unloading merchandise on racks and sustained a lower back injury. In a 4/2/14 follow-up, subjective complaints included continued low back pain radiating down the left > right legs, difficulty walking more than a few blocks, and sitting and standing tolerance of 20 minutes. Objective findings included lumbar tenderness, 4-/5 strength left EHL, and decreased sensation in bilateral L4 and L5 distributions. Objective findings in a 4/30/14 follow-up were decreased sensation in bilateral L5 and S1 distributions. Objective findings in a 6/11/14 follow-up included decreased sensation in the L5 and S1 nerve root distributions and symmetric reflexes. Lumbar x-rays on 8/1/12 showed decreased disc height at L4-5 and L5-S1 with 1 mm L4-5 retrolisthesis. Lower extremity EMG/NCV studies on 10/23/13 showed mild-moderate left L5 and S1 sensory radiculopathy. A lumbar spine MRI on 4/18/14 showed a 3 mm disc protrusion at L5-S1 resulting in abutment of the descending S1 nerve roots bilaterally as well as abutment of the exiting right and left L5 nerve roots. There was moderate canal narrowing at L4-5, a 3 mm L4-5 disc protrusion with abutment of the descending L5 nerve roots bilaterally, and abutment of the exiting right and left L4 nerve roots. Diagnostic impression: lumbar radiculopathy. Treatment to date: epidural steroid injection at L3-4 without benefit, trigger point injections, physical therapy, medications. A UR decision on 7/31/14 denied the request for lumbar fusion on the basis that there was no evidence of instability and, in a peer to peer discussion; [REDACTED] agreed that only a decompression was needed. The requests for a reacher/grabber, elevated toilet seat, front-wheeled walker, bone growth stimulator, psychological evaluation, and post-op aquatic therapy were denied because the lumbar fusion was not certified. The request for post-op physical therapy was modified to allow for 8 sessions because the laminectomy portion of the procedure was approved. The

request for pre-op chest x-ray was denied because there was no description of the patient being a cigarette smoker.

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

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

#### **Possible Instrumental fusion at L4-5 and L5-S1 with pedicle screws and Transforaminal Lumbar Interbody Fusion: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

**Decision rationale:** CA MTUS states that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. In the present case, there is no documented evidence of spinal instability, fracture, dislocation, or spondylolisthesis. There are no lumbar flexion/extension x-rays that would show instability, and there is no evidence of spondylolisthesis on MRI. Therefore, a lumbar fusion does not appear to be supported, although the patient does have radiculopathy. The previous UR determination does show an indication that the surgeon agreed to modify the request to allow for a decompression only so that the radicular complaints could be addressed. Therefore, the request for Possible Instrumental fusion at L4-5 and L5-S1 with pedicle screws and Transforaminal Lumbar Interbody Fusion is not medically necessary.

**Reacher/grabber:** 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.

**Elevated toilet seat:** 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.

**Front-wheeled walker:** 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:** 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.

**Psychological evaluation:** 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 physical therapy #9:** 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 aquatic therapy:** 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.

**Preoperative chest x-ray #1:** 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.