

<b>Case Number:</b>	CM14-0128735		
<b>Date Assigned:</b>	08/18/2014	<b>Date of Injury:</b>	09/22/1999
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	07/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/13/2014

### 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 Neurological 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:

The records, presented for review, indicate that this 58-year-old individual was reportedly injured on September 22, 1999. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated January 9, 2014, indicated that there were ongoing complaints of severe pain in the cervical spine, lumbar spine, left shoulder, left upper extremity and right knee. The physical examination demonstrated tenderness to palpation of the cervical spine associated with a decreased range of motion. No sensory deficit was identified. The lumbar spine examination noted tenderness to palpation, muscle spasms, a limited range of motion and a positive straight leg raise. The sensory deficit was reported in the L3, L4 & L5 distributions. There was tenderness about the left shoulder with a restricted range of motion. There was tenderness over the left elbow and left wrist. A restricted range of motion of the right knee was also reported. Diagnostic imaging studies reportedly demonstrated a disc protrusion at L5-S1. Previous treatment included multiple surgeries involving the left elbow, left shoulder, right knee, physical therapy, multiple medications, and pain management interventions. A request had been made for posterior lumbar discectomy, decompression and fusion with instrumentation, allograft and bone morphogenetic protein at L4-L5 and L5-S1 levels, hospital stay 2-3 days, postop physical therapy, lumbar brace, and cold therapy and was not certified in the pre-authorization process on July 30, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Posterior Lumbar Discectomy, Decompression And Fusion With Instrumentation, Allograft And Bone Morphogenetic Protein At L4-L5 And L5-S1 Levels: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,303-4,307.

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

**Decision rationale:** 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. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. 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. The request is not medically necessary.

**Hospital Stay 2-3 Days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,303-4,307.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter updated September, 2014.

**Decision rationale:** The underlying surgical request is not medically necessary. Hospitalization is also not medically necessary.

**Post-Op Physical Therapy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,303-4,307.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The underlying request for surgical intervention is not medically necessary, Postoperative physical therapy is not medically necessary.

**Lumbar Brace: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,303-4,307.

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

**Decision rationale:** When noting that the underlying surgical request is not medically necessary, a lumbar brace is not medically necessary.

**Cold Therapy Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,303-4,307.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain chapter, updated September 2014.

**Decision rationale:** In that the underlying surgical request is determined not to be medically necessary, there is no medical necessity for this postoperative cold therapy unit.