

<b>Case Number:</b>	CM14-0129224		
<b>Date Assigned:</b>	08/18/2014	<b>Date of Injury:</b>	02/28/2011
<b>Decision Date:</b>	12/15/2014	<b>UR Denial Date:</b>	07/24/2014
<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 Orthopedic Surgery, has a subspecialty in Spine 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:

According to the records made available for review, this is a 59-year-old male with a 2/28/11 date of injury, and L5-S1 percutaneous discectomy on 4/14/14. At the time (6/26/14) of request for authorization for L5-S1 Posterior interbody fusion allograft any repair and associated surgical services, there is documentation of subjective (constant low back pain and bilateral lower extremities pain) and objective (decreased range of motion of the lumbar spine, L5 dermatome weakness, and positive straight leg raise) findings. MRI of the Lumbar spine (6/13/12) report revealed diffuse disc protrusion affecting the thecal sac at L4-L5; and L5 exiting nerve roots are unremarkable. The current diagnoses are thoracic/lumbar neuritis, degeneration lumbar disc disease, lumbago, and displacement of lumbar intervertebral disc. The treatment to date includes physical therapy, chiropractic treatments, acupuncture, and medications. There is no documentation of an indication for fusion (instability OR a statement that decompression will create surgically induced instability).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 Posterior Interbody Fusion Allograft, any repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Fusion (Spinal)

**MAXIMUS 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 Discectomy/laminectomy and Fusion (spinal)

**Decision rationale:** MTUS reference to ACOEM identifies documentation of severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Failure of conservative treatment; and an Indication for fusion (instability OR a statement that decompression will create surgically induced instability), as criteria necessary to support the medical necessity of laminotomy/fusion. Official Disability Guidelines identifies documentation of Symptoms/Findings which confirm presence of radiculopathy, objective findings that correlate with symptoms and imaging findings in concordance between radicular findings on radiologic evaluation and physical exam findings, as criteria necessary to support the medical necessity of decompression/laminotomy. Within the medical information available for review, there is documentation of diagnoses of thoracic/lumbar neuritis, degeneration lumbar disc disease, lumbago, and displacement of lumbar intervertebral disc. In addition, there is documentation of a L5-S1 percutaneous discectomy surgery on 4/14/14. However, there is no documentation of an indication for fusion (instability OR a statement that decompression will create surgically induced instability). Therefore, based on guidelines and a review of the evidence, the request for L5-S1 Posterior Interbody Fusion Allograft any repair is not medically necessary.

**EKG (Electrocardiogram):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter

**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.

**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, Pulmonary Chapter

**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.

**CBC (Complete Blood Count):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopaedic Surgeons: Preoperative Lab Work in the Appropriate Clinical Situation

**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.

**BMP (Basic Metabolic Panel):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopaedic Surgeons: Preoperative Lab Work in the Appropriate Clinical Situation

**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.

**Urinalysis:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopaedic Surgeons: Preoperative Lab Work in the Appropriate Clinical Situation

**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.

**PT (Prothrombin Time) / PTT (Partial Thromboplastin Time):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopaedic Surgeons: Preoperative Lab Work in the Appropriate Clinical Situation

**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.

**Back Brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back Chapter

**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 three times a week for three weeks, QTY: 9:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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.