

<b>Case Number:</b>	CM14-0214087		
<b>Date Assigned:</b>	12/31/2014	<b>Date of Injury:</b>	08/09/2014
<b>Decision Date:</b>	03/03/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/22/2014

### 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. 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 54-year-old male who reported an injury on 08/09/2014. The mechanism of injury was not provided. He had a history of back pain. On 10/30/2014, the injured worker was seen for re-evaluation. The injured worker reported intermediate moderate low back pain that was exacerbated by movement and strenuous activity. He also stated a constant tingling sensation in both feet, worse in the left. He sometimes trips and stumbles due to loss of sensation in feet. Upon examination of the lumbosacral spine, there was tenderness about the paralumbar musculature with tenderness at the midline thoracolumbar junction and over the level of L5-S1 facets and right greater sciatic notch. There was restricted range of motion due to complaints of pain. There were muscle spasms. Straight leg raise was positive bilaterally at 70 degrees, Lasegue's test was positive bilaterally. Sensory to light touch and pinprick was decreased on L5 dermatome on the right. Muscle strength was decreased on L5 myotomes bilaterally. Current diagnoses included lumbar spine sprain/strain with radicular complaints and lumbar discopathy. The treatment plan included an orthopedic re-evaluation. The injured worker had been treated conservatively with 2 ESIs, physiotherapy for 4 months, acupuncture for more than 15 times, and chiropractic treatment that has failed to relieve his low back pain. The injured worker has had 20 sessions of physical therapy, 20 sessions of acupuncture and 2 epidural steroid injections with on relief of her symptoms. It was felt the injured worker would be a surgical candidate for an anterior lumbar interbody fusion of L5-S1, Gill laminectomy of L5-S1 including decompression foraminotomy only at L5-S1 to address the pathology. It was stated the injured worker should be provided a lumbar Cybertech brace for postoperative support.

The injured worker should have postoperative cryotherapy 1 month at 3 to 5 times a day. The injured worker should have preoperative medical clearance. There is a need for an assistant surgeon to facilitate the procedure and process of surgery. The injured worker's procedure requires a vascular surgeon to get anterior access to a retroperitoneal approach. The injured worker should be provided a bone stimulator to help the fusion surgery take successfully and prevent additional spinal surgeries. The request is for anterior lumbar interbody fusion of L5-S1, Gill laminectomy of L5-S1 including decompression foraminotomy at L5-S1; prefabricated lumbar brace purchase; postoperative bone stimulator purchase; and postoperative cryotherapy for 1 month 3 to 4 times per day.

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

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

#### **Anterior lumbar interbody fusion of L5-S1, Gill laminectomy of L5-S1 including decompression foraminotomy at L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Low back, indications for spinal decompression and fusion

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

**Decision rationale:** The request for anterior lumbar interbody fusion of L5-S1, Gill laminectomy of L5-S1 including decompression foraminotomy at L5-S1 is not supported. The Official Disability Guidelines do not recommend spinal fusion for patients who have less than 6 months of failed recommended conservative care unless there is objectively demonstrated severe instability or neurological dysfunction. Laminectomy is recommended for lumbar spinal stenosis. The injured worker has low back pain that radiated to the bilateral legs with numbness and tingling. He has neurological deficits at the L5 nerve root distribution. The MRI showed disc protrusion facet arthropathy, and spinal stenosis and neural foraminal stenosis at L5-S1. The injured worker has failed conservative care. It is not clear the injured worker has spondylosis based on clinical information submitted. Gill laminectomy of L5-S1 including decompression foraminotomy at L5-S1 may be recommended; however, the anterior lumbar interbody fusion of L5-S1 is not supported. As such, the request is not medically necessary.

#### **Pre-fabricated lumbar brace purchase: 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 bone stimulator purchase: 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 cryotherapy for 1 month 3-4 times per day: 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.