

<b>Case Number:</b>	CM14-0155875		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	03/14/2012
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	09/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 Spine Surgeon, and is licensed to practice in Texas. 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 injured worker is a 52-year-old male who reported an injury on 03/14/2012 due to a motor vehicle accident. The injured worker reportedly sustained an injury to his neck and low back. The injured worker's treatment history included medications, physical therapy, activity modifications, and epidural steroid injections. The injured worker underwent an MRI of the lumbar spine dated 06/14/2014 that documented a disc bulge at the L3-4, causing moderate bilateral neural foraminal narrowing; a disc bulge at the L4-5, causing moderate bilateral neural foraminal narrowing; and a disc bulge at the L5-S1, causing mild right and moderate to severe left neural foraminal narrowing. The injured worker was evaluated on 08/01/2014. It was documented that the injured worker has 8/10 cervical and lumbar spine pain. Physical findings included tenderness to palpation of the right iliac crest region of the lumbar spine, with restricted range of motion secondary to pain and decreased sensation to the lateral thigh and anterolateral thigh, leg and foot, anterior knee and mid leg and foot, correlative of an L4-5 dermatomal distribution. The injured worker had reduced motor strength rated at a 4/5 in the quadriceps, extensor hallucis longus, and L4 and L5 innervated muscles. The injured worker's diagnoses included cervical and lumbar discopathy, and cervicgia. The injured worker's treatment plan included surgical intervention. A Request for Authorization form was submitted on 09/05/2014 to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L3-L5 posterior lumbar interbody fusion (PLIF) with reduction of listhesis: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation Low Back Procedure Summary

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

**Decision rationale:** The requested L3-4 posterior lumbar interbody fusion with reduction of listhesis is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends fusion surgery for patients who have documented instability of the lumbar spine. The clinical documentation submitted for review does not provide any evidence that the injured worker has instability. There is no documentation of a retrolisthesis of Anterolisthesis on any of the recent imaging studies provided. Furthermore, the American College of Occupational and Environmental Medicine recommends a psychiatric evaluation prior to spine surgery. The clinical documentation submitted for review does not provide any evidence that the injured worker has undergone a psychological evaluation to assess that they are an appropriate candidate for spine fusion. As such, the requested L3-4 posterior lumbar interbody fusion (PLIF) with reduction of listhesis is not medically necessary or appropriate.

**2-3 days hospital stay:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Treatment in Workers Compensation Low Back Procedure Summary

**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 wheel walker purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation official Disability Guidelines (ODG); Treatment in Workers Compensation Knee and Leg Procedure Summary

**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.

**Ice Unit purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-Treatment in Workers Compensation Low Back Procedure Summary

**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 stimulator purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Low Back Procedure Summary

**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.

**TLSO purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Low Back Procedure Summary

**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.

**3-1 commode purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment CG-DME-10

**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.

**Medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Treatment in Workers Compensation Low Back Procedure Summary

**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.