

<b>Case Number:</b>	CM13-0038969		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	09/05/2012
<b>Decision Date:</b>	03/10/2014	<b>UR Denial Date:</b>	09/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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 patient is a 42 year old male who reported an injury on 09/05/2012. The patient is diagnosed with central disc herniation at L4-5, left-sided disc herniation at L5-S1, and weakness to the right quadriceps. The patient was seen by [REDACTED] on 07/17/2013. The patient reported progressively worse pain with difficulty arising from a seated position. Physical examination revealed positive straight leg raise bilaterally, decreased sensation in the left S1 distribution, and weakness in the right quadriceps. Treatment recommendations included a 2 level fusion at L4-5 and L5-S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal Lumbar Interbody Fusion (TLIF) L4-S1, Bilateral Pedicle Screw Rod Fixation and Arthrodesis:** 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 Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Decompression, Fusion (spinal)

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitations, extreme progression of lower extremity symptoms, clear clinical, imaging, and electrophysiological evidence of a lesion that has been shown to benefit from surgical repair, and a failure of conservative treatment to resolve symptoms. Patient's with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for a fusion. As per the documentation submitted, the patient demonstrated positive straight leg raise bilaterally, decreased sensation in the left S1 distribution, and weakness in the right quadriceps. There were no flexion and extension view radiographs submitted for review to document instability. There has also not been any psychological evaluation prior to the requested surgical intervention. While the patient may meet criteria for a decompression, the medical rationale for a fusion has not been provided. Without evidence of instability, the patient does not currently meet criteria. As such, the request is non-certified.